

ROSEHIP MEDIC COLLECTIVE

20-Hour Street Medic Training



Statement of Values

We support all people's rights to understand, access, and direct their own health and wellness.

We envision a world free of all oppression and seek solidarity with those struggling towards personal and collective liberation.

We believe that the personal is political and that self-care and mutual aid are necessary to sustain resistance.

We embrace a philosophy of harm-reduction and non-judgmental care.

Primum non nocere: First, do no harm

Whatever action you may take, first consider the possible harm that action may cause.

This manual represents a brief introduction to the kinds of skills needed by street medics and is not a substitute for longer, more in depth, experiential training. These documents are free to judicious users for reproduction and modification. We request that our group name be removed from modified documents and that the user teaches and practices only what they know.

"Judicious users" will here signify those who share philosophies of harm-reduction and anti-oppression—to the exclusion of law enforcement, legal and political establishments, and all for-profit enterprise. If you do not qualify as a 'judicious user', additional permissions and paid contract must be requested in writing. We can be reached at: rosehipmedics@gmail.com or by visiting our website: www.rosehipmedics.org

Updated: February 2019

About This Manual

This manual is the result of eight years of work by the Rosehip Medic Collective. It has been through countless revisions, has been printed for many 20-hour street medic trainings, and forms the outline for what you will learn over the course of this weekend. We hope that this manual will be a useful resource for understanding and remembering everything we will cover in the training, however it can't cover everything, so we encourage you to take good notes. We hope that this document will serve you in the future as a reference, and as a way to refresh your skills.

Reading this manual is not a substitute for a street medic training. The hands-on process of completing a 20-hour street medic training is recognized as the standard for representing one's self as a street medic.

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1.0 Welcome

Fight the power; do no harm

1.1 Our Goals

- To train effective street medics with a solid base of information and skills, who know when and how to get help
- Have our values reflected in the manner in which we train and practice
- Increase access to a variety of medical traditions and knowledge
- Build community and strengthen networks of street medics and other infrastructure
- Promote a culture and practice of collective and independent learning
- Receive feedback to Improve our training

1.2 Ground Rules

Take care of yourself

This training may bring up difficult memories for some people, and will challenge us in different ways. Know and assert your limits; step back or take space if you need to; tell other folks if you have specific needs or don't want them doing something. If you are distressed, let us know and we'll try to help. Participate as much as you are able and comfortable doing so. Know that all activities are optional and that you are free to step back and participate as a viewer if you need to.

We will do a lot of hands-on practice, so let us know if we can do something to help you remain as engaged as fully as possible. If you need something, chances are that others might need it too. If you need a bathroom break, want more explanation, need more hands-on practice, let us know.

Take care of each other

Be accountable for your words and actions—and ask rather than assume. Respect and value each other. Everyone here has important, useful knowledge and experience. Understand that all people don't share the same experience and that there are occasionally different protocols for the same first aid procedure. We teach the ways we know and believe are best for

the tasks at hand, but we recognize that many other protocols work as well.

Touching and privilege

Ask for consent each time you touch someone and each time you do something new. Be sensitive and responsive to messages you receive from other folks. Not everyone feels comfortable saying, “don't do that” or “that was an insensitive thing to say” but they can indicate those reactions in other ways.

Be aware of how much space you take up, and if the space you take is well-balanced with others in the room. If you haven't spoken as much as others, step up; if you are taking more space than others—particularly people that have less privilege than you—step back and give others that space.

Keep confidentiality within this room. Don't share stories outside unless someone has given explicit permission for you to share an experience or story about them.

Take care of your trainers

Trust us. There may be times when you feel you are being asked to do things without enough knowledge

or are only learning part of the information. By the end of the weekend, this should come together.

Be engaged, be active, help each other out, and ask questions.

Tell us if you disagree with anything we do, or have more questions. We make mistakes and depend on each other to catch them.

It is very important that we begin the day and come back from breaks on time.

We need to pack a lot into this weekend, and need to keep a balance between presentations, responses, clarifications, hands-on and interactive learning,

and breaks so that people don't become bored or burnt out. There may be times when we won't be able to answer questions or go over things again. Please, write your questions down and ask us at one of the breaks and we'll clarify or practice more.

Take care of the people we treat

Medicking is an enormous honor and responsibility.

DO NO HARM - work within your limits and ask for help when you need it.

Be willing to make mistakes now and let others know when they make them.

1.3 Why Street Medic

As street medics, we can:

- Keep people safe and healthy at protests/actions encampments
- Encourage people who might otherwise feel unsafe at protests to come out and speak up
- Help maintain healthy communities of resistance by supporting activists and folks bearing the brunt of oppression
- Help ensure every person can be treated by a medical provider they feel comfortable with
- Model decentralized methods of providing healthcare outside of the dominant framework of oppressive healthcare
- Share the resources and skills that we have, and create networks for people to access resources of their choosing
- Help people stay at protests when they might otherwise need to go home because of illness or injury
- Help reduce some barriers to participating in protest for people with chronic/ongoing medical conditions or disabilities

1.3.1 Why NOT to Street Medic

Medicking is hard work. Many of us carry heavy packs around on long marches, spend long hours inside when we'd rather be out in the sunshine, and are faced with situations ranging from incredibly dull yet tense shifts at clinics to making hard decisions in situations that are already scary and complex. Medicking is also exciting for many of us; we meet wonderful people, get to learn interesting things and people are usually really nice to us. We ask crowds to make space for us, we are often given a lot of respect and attention, and it's easy for us to end up "in the middle of the action" on a regular basis.

Because this is hard and exciting work we have to be honest with ourselves about what we're doing and why. Many of us come to this work for one or many of the wrong reasons; we like the attention, we want to feel like heroes, we feel compelled to make martyrs of ourselves, we work too hard, or maybe we always want to be where the action and excitement is. Recognizing those feelings and remembering that those impulses may eventually lead to burn-out, feelings of frustration, and sometimes even put our patient's and our own well-being and safety at risk. Acknowledging our motivations lets us honor the place we're at but also move us towards the long-term rewards of being part of the medic community.

1.4 Guiding Street Medic Principles

Do No Harm

This is the first principle of all types of medical work. “Do No Harm” means that we must consider the possible outcomes of any intervention before we perform it – this means considering whether the benefits outweigh the possible harm caused. This also applies to the benefits and possible harm of not taking an action. “Do No Harm” includes following the other principles laid out below.

Spread Calm

Confrontations with difficult situations are both exciting and frightening. Running makes us prone to tripping or trampling others—panic only weakens us. In crisis situations people tend to mirror the emotional responses of those around them. Encourage crowds towards a safer position by saying, “let’s walk over here,” for example, is far safer (and more efficient) than shouting, “Run!”

Do Not Create a Second Patient

If you are injured or incapacitated, you will not only be unavailable to help, but you will need to be attended to as well. A medic’s first priority is themselves; a medic’s second priority is their buddy. When a medic is hurt their buddy becomes unavailable to others until treatment and recovery are complete. By getting into a situation that gets you injured, you are taking two or more medics away from others.

Stay Within Your Scope

Scope means how much medical knowledge one has and what skills one has training to use. Knowing each other’s scope allows us to understand who needs to be guiding the care for a patient or patients—generally the person with the most training relevant to the patient’s situation (especially in emergency situations). More training and higher levels of certification increase one’s scope and allow one to ethically and legally perform more medical services.

When considering scope it’s important to remember that different medical fields have different certification practices, if any. Often the only way to

really understand another person’s scope is to work and talk with them at length; thus, accurately representing your own scope is extremely important. Because we cannot and should not rely solely on the state to authorize us as medical providers, it is our reputations and personal accounts that convey what we are able to do.

Know What to Do When You Don’t Know What to Do

We see patients all the time who confuse us. We don’t know what to do with them, and their symptoms don’t make any sense and don’t lead us to a logical intervention. Maybe the patient looks so bad when we first lay eyes on her that we panic, feel inadequate and reconsider why we thought becoming a medic was a good idea in the first place. Know what to do when these feelings strike. No matter what is wrong with the patient, you cannot go wrong by following the triangle system that we will be teaching over the next few days.

Slow is smooth, smooth is fast

Our response to high-intensity situations is often to speed up, panic, fight or run. At times those instincts are absolutely vital to our survival, but being a good medic means knowing when to suppress the urge to speed up. Take time to be methodical, learn the assessment system, and go through it slowly and thoroughly, and you will make fewer mistakes. Sloppy mistakes cost time and can do harm.

It’s not our emergency

This is a tricky one. It isn’t our emergency — we’re not the one hurt, sick, in pain. It can feel like our emergency because we care about our patients, and it’s hard not to empathize while we’re medicking them. It’s okay to know that the patient is in pain, and want to help the patient be restored efficiently and effectively. We should avoid letting that desire to help push us into a state of franticness, of rushing, of taking on our patient’s pain, which will all get in the way of allowing us to help the patient.

1.5 Legal Aspects of Being a Street Medic

Good Samaritan Laws in the U.S. generally provide protection for those providing emergency medical assistance. They offer protection only for people who have no “duty to act” (i.e., it is not part of your paid job description to provide care) and who do NOT expect to receive pay for their services.

Here are a few important things to keep in mind when providing aid:

Only work to the level of your skill

You are protected as long as you do what other people of your skill level would reasonably do. For example, if you aren't trained for CPR, don't do CPR. If you are trained as a Wilderness First Responder (WFR), you can provide the level of care a WFR would normally provide, and you will be held to a standard of care that a WFR is trained to.

Never abandon a patient

Once care is started you must stay with the patient until someone with your level of training or higher is ready to take over care. If you leave the patient after you have started care, you could be sued for abandoning the patient.

Obtain consent if the person is able to give consent

Methods for obtaining consent are described in the section on Streetside Manner. Consent is legally and ethically required. If the situation involves a serious risk of death, disability, or worsening of the condition and the person is not mentally competent, consent is considered implied. If the person is under fifteen years of age and their parents are not there to consent, consent is implied. Consent is discussed in further detail in section 3.2.

Keep your certifications current!

You are not legally required to give aid in Oregon (no "duty to act"). However, if you do have training or certification recognized by the state, you may want to be familiar with the legal aspects of negligence associated with your training.

Patients can refuse care at any time.

Oregon and Washington Good Sam Law

Oregon (30.805):

(2) No person may maintain an action for damages for injury, death or loss that results from acts or omissions of a person while rendering emergency medical assistance unless it is alleged and proved by the complaining party that the person was grossly negligent in rendering the emergency medical assistance.

(3) The giving of emergency medical assistance by a person does not, of itself, establish a professional relationship between the person giving the assistance and the person receiving the assistance insofar as the relationship carries with it any duty to provide or arrange for further medical care for the injured person after the giving of emergency medical assistance. [1967 c.266 §§1,2; 1973 c.635 §1; 1979 c.576 §1; 1979 c.731 §1; 1983 c.771 §1; 1983 c.779 §1; 1985 c.428 §1; 1989 c.782 §35; 1997 c.242 §1; 1997 c.751 §11; 2013 c.688 §8; 2014 c.45 §3]

Washington (4.24.300):

(1) Any person, including but not limited to a volunteer provider of emergency or medical services, who without compensation or the expectation of compensation renders emergency care at the scene of an emergency or who participates in transporting, not for compensation, therefrom an injured person or persons for emergency medical treatment shall not be liable for civil damages resulting from any act or omission in the rendering of such emergency care or in transporting such persons, other than acts or omissions constituting gross negligence or willful or wanton misconduct. Any person rendering emergency care during the course of regular employment and receiving compensation or expecting to receive compensation for rendering such care is excluded from the protection of this subsection.

(2) Any licensed health care provider regulated by a disciplining authority under RCW 18.130.040 in the state of Washington who, without compensation or the expectation of compensation, provides health care services at a community health care setting is not liable for civil damages resulting from any act or omission in the rendering of such care, other than acts or omissions constituting gross negligence or willful or wanton misconduct.

<http://www.leg.state.or.us/ors/030.html>
<http://apps.leg.wa.gov/RCW/default.aspx?cite=4.24.300>

2.0 Pre-Action Preparation

2.1 Medic Fashion and Kits

Dress to protect yourself. Here are some ideas:

- Wear long sleeves, cover legs so skin is not exposed
- Wear layers
- Closed-toe shoes that you can walk in for a long time.
- Wear water-based sunscreen (oil-based products may trap chemicals such as pepper spray)
- DON'T wear contacts. Carry an extra pair of prescription glasses.
- DON'T wear tampons if you are menstruating; in the case of arrest it may be a long time before they can be changed.
- Minimize the use of cotton as a base layer or outer layer, because when it gets wet it leeches heat from the body

Along with what to wear comes what to carry. A list of possible items for a medic kit is included in the appendix; remember that carrying gear we don't know how to use just wastes space and energy. When packing our kits and geeking out over tools, it's important to remember the basics of what really lets us help people:

- Our knowledge and skill (and knowing our limits)
- Cell phones for getting additional resources
- Gloves for touching patients
- The absolute BEST medic tool ever invented - a second set of hands, eyes, brain, skills and knowledge - your MEDIC BUDDY!

2.2 Buddies

As street medics we work in pairs, or sometimes in trios. Multiple buddy pairs can also work as a team.

Reasons for buddies:

- To keep each other safer
- To have a witness for medical and non-medical actions we take
- To increase confidence
- To have a second opinion
- Because another person adds their own skills, experience, and perceptions
- For emotional support
- Increased likelihood a patient will feel comfortable with one of the medics
- Often several roles need to be carried out – to treat the patient, to assist, to watch the scene, to

direct the crowd, to communicate with other medics or Emergency Medical Services (EMS), to interact with cops or other folks trying to interfere

- Some injuries require more than one person to carry out the treatment
- Because it's more fun! We like to make up buddy team names, songs, or dances

The importance of a buddy whom you trust and work well with cannot be overstated. Take time to get to know your buddy and practice together before an action if you can. Your buddy is your single most important piece of medical equipment!

Things to consider when choosing a buddy:

- Someone you feel safe with.
- Methodology - Near the front or near the back? Chanting or quiet?
- Arrestability - Sometimes referred-to as red, yellow or green. Remember that there is no way to be sure of avoiding an arrest but being on the same page with our buddies can help us avoid some uncomfortable situations.
- Focus - stay on the streets or go to jail support as soon as there are arrests?

Try to break up skills, experience, strengths and weaknesses between different groups so that all the resources don't get concentrated. Such as:

- Languages spoken
- Differing experience or training levels
- Gender
- Communication or police liaising skills
- Stress tolerance levels

Things to discuss with your buddy or team before an action:

- General mood and well-being (tired, anxious, excited)

2.3 Ethics of Medicking

As medics, we have a responsibility to know ourselves before we go out to provide care to others.

Some possible dilemmas each of us should think about, and possibly discuss within buddy pairs, teams or affinity groups before an action:

- How much does your presence support the cause of the action? How fully should you understand the topic/purpose of the action before committing to go? Will you leave if the topic of the march changes significantly or if you were misinformed?
- Would you medic someone you strongly disagreed with (i.e. a cop, nazi, counter-protester)? Is it possible to maintain a safe scene while treating someone who may be hostile to you? Is medicking a cop or nazi following Do

- Risks: willingness to risk arrest and willingness to risk physical harm
- Legal issues: citizenship, parole, prior arrests
- Areas of strength and weakness, special skills
- Previous experience with demos/as a medic
- Exchange phone numbers: make sure both have numbers for legal, jail support, medic dispatch,
- Communications: who will carry/use the radio or cell phone?
- Limits: physical, emotional, mental, other
- How you respond to stress, things to be aware of, things to avoid, what your buddy should or should not do if you are stressing or upset.
- What you need for self care
- Physical conditions such as asthma, allergies, diabetes, pregnancy, injuries, medical conditions that might be relevant
- Where your spare glasses, inhaler, and other things are
- Meeting plan if separated (especially if one does not have a phone)
- Philosophy — See 2.3, Ethics
- Hopes/goals/intentions
- Debrief and feedback plans: make (and plan) space and time for this to happen—both with your buddy and any medic/other affinity groups

No Harm principles? What if the counter-protester is injured doing something against the action (like fighting with folks on your side, removing a banner)?

- Would you treat someone involved in the protest that was injured doing something you don't approve of/support (splitting a march with vulnerable folks in it, blocking traffic near a hospital)? How would you deal with a patient you are treating who is using oppressive language in front of you, or possibly towards you or your buddy?
- What other infrastructure will you work with? Will you work with legal support if lawyers are running it? Will you work with the "protest security" if they are allied with the police?

2.4 Horizontal/Vertical Infrastructure

Horizontal

Part of preparing as a street medic is being familiar with your resources—especially people. Besides your buddy, there may be other medics—do they have buddies? Phones? What kind of training/certification/scope do they have? What sort of gear are they carrying? Where do they plan to be in the action and how will you communicate?

If you are new to town, connecting with other medics may help familiarize you with local hospitals, community health and wellness resources, police behaviors, features of the march route, and community-specific needs.

Besides all this practical information, pre-action exchanges can be great opportunities to meet other medics and form relationships that can prove vital in the streets and encourage more long-term cooperation.

Although varied and tiered, we can consider many medical resources as parts of our horizontal infrastructure. Depending on scale, these roles may be dispersed among street medics or separated out:

- Safe and Healthy in the Street training (prevention!)
- Briefings, dispatch, and communications
- Clinicians
- Wellness and alternative modalities (herbs, body work, acupuncture, energy work)
- Decontamination (chemical weapons)
- Emotional Trauma team
- Sexual assault survivor advocates

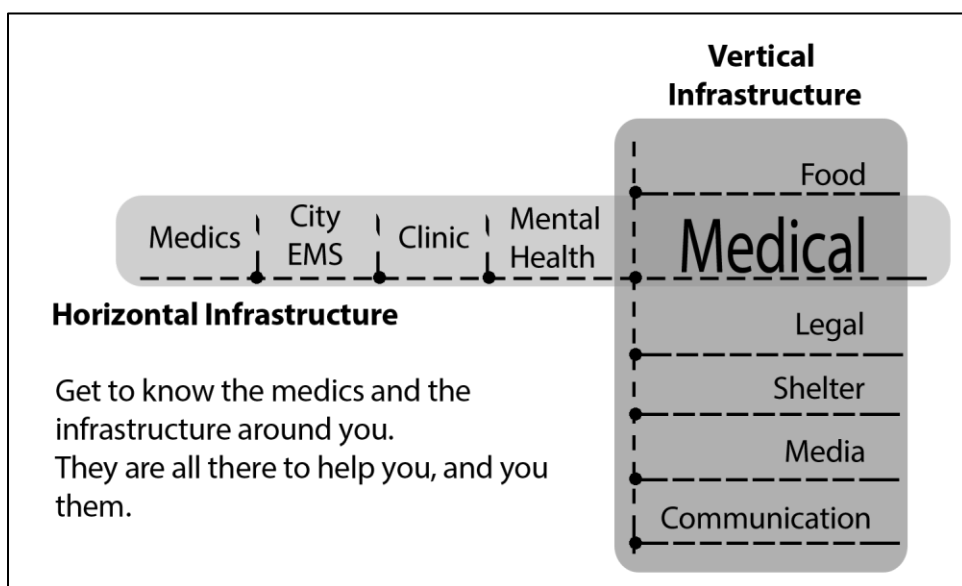
Vertical

Similarly, exchanging information and contacts with folks in other roles in a mobilization can help you to understand pre-planned routes, plans, and emergency procedures. Knowing how to reach a police liaison or organizer could save you

and your patient a trip in a police van. Maybe the pace of a march is too rapid, there is lots of sun, and several participants are dangerously approaching heat exhaustion. This is a much more manageable problem if you can contact the organizers and ask them to slow down/stop in a shady area, and to send helpers with water. Jail support numbers are invaluable—for you and your patients. Ten minutes of mingling and introduction before an action can save hours of frustration later. Medics may organize some of these roles because no one else has done so, or to ensure adequate support for each other.

Some of the vertical infrastructure we interact with and appreciate includes:

- Jail support
- Legal observers and/or Copwatch
- Event organizers
- Police liaisons
- Other liaisons – media, workers, public (especially when there is a risk of cross-community violence or antagonism)
- Communications
- Independent (“Our”) Media, Social Media, Livestream
- Food and water (food not bombs, water-carriers)
- Safe housing



2.5 Introduction to Prevention

Aside from immediate pre-action concerns, our day-to-day health and well-being have a huge impact on how effective we are as activists. By caring for ourselves, our friends and fellow activists, we sustain ourselves and provide a strong backbone for the movement. There are simple preventive measures that we can all take to avoid injuries on the streets, and mitigate illness that results from stress, dehydration, exhaustion, and exposure to chemicals.

Food

Remember to eat before and after an action, and during if it goes on for a long time

Stress can disrupt our normal food routine; try to eat nourishing foods at regular intervals

Some foods are considered healthier than others. Eat the foods that make you feel good. Eating is an important way that we can take care of ourselves.

Water

Drinking water is important. Shoot for 6-8 glasses a day, or whatever feels good to you.

Alcohol/Drugs/Medicine/Sobriety

You should only medic at your baseline. Take your medicines as prescribed. Partying hard the night before an action can leave you ill-prepared to medic the following day. Know yourself and your limits, think of Medicking like operating heavy machinery.

Plant medicines

There are many plants that can strengthen your health. Many of them are considered weeds and can be found throughout the city. If you decide to harvest plants yourself, get them from areas that are as clean as possible: community gardens, gardens at

your homes if pesticides are not used. Good plants for liver and kidney detox and general good health include: nettles, dandelion, cleavers, burdock, chickweed, cheeseweed (related to marshmallow), artichoke leaf, and milk thistle. They are described in more detail in the Aftercare section.

Stress and sleep

Stress is generally regarded as a bad thing that leads to anxiety, depression, or illness, but it's good to keep in mind that there are good forms of stress, such as physical stress from exerting yourself during a bike ride or lots of social time. Reducing stress (good or bad) a before an event can help your body conserve resources. Be familiar with how your body, mind, and emotions respond to stress. This can affect your capacity to be a good medic and may reduce the scope of work you are comfortable doing. Whenever possible, you want to be at your best physically, emotionally, and mentally during an event, because those events are stressful.

Try to get enough sleep. Sleep deprivation can lead to unclear thinking and poor decision making; the last two things you want when you are a street medic.

3.0 Streetside Manner

Like bedside manner, but with fewer beds

3.1 Introducing Yourself

Approach a (potential) patient slowly and with confidence. Be conscious of your tone of voice, body language, and eye contact. Make sure you approach a patient on their level and from the front, don't make patients turn their head to see you. If a person is lying down, approach from the feet. Say, "Hi, my name X. and I'm a street medic/I have some medical training. Can I help you?"

3.2 Consent

There are two kinds of consent relevant to a street medic: informed consent and implied consent

Informed and expressed consent

Informed and expressed consent is present when you say what you want to do, why, and what the risks might be, AND a reliable patient expresses consent to treatment.

Implied consent

Implied consent is a legal assumption that an unresponsive or unreliable patient would want help during an emergency.

Unreliable patients

An unreliable patient is considered to be any patient who is not fully alert and oriented to person, place, and time—and/or is intoxicated. Examples include patients who are unresponsive, intoxicated, have a head injury, screaming 6 year-olds, or patients who are not acting as they usually do. Everyone has a different normal though—so talk to their friends if possible to find out if this person is acting "abnormally."

Implied consent applies legally to minors whose parents are not available to give consent. The age of consent in Oregon is 15. The age of the patient does not matter if the patient is asking for help. For example, a 16-year-old who says, "help me!" is able to give expressed consent, while a 14-year-old who says, "help me!" is not legally giving expressed

consent but has the overriding implied consent due to being a minor.

The difference applies to the patient who denies consent. A 16-year-old who says, "don't touch me!" is legally denying care. A 14-year-old who says, "don't touch me!" can legally be treated. As radicals, we do not deal only with legalities but also with the ethics of consent. Consider the situation and how to do the least amount of harm when dealing with someone under the legal age of consent who asks you not to touch her.

- Consent for responsive patients is crucial!
- Don't touch someone without permission.
- Continue to get consent throughout the treatment for every new thing you want to do.
- Make sure you check in so that you are following the patient's wishes.
- It is OK for someone to not give consent!
- If individuals don't consent, encourage them to define the problem. See if the concern is something that can be worked with.
- If the patient does not consent, alert her friends of problems that may arise and what they can do to help. If a combative patient refuses consent, don't fight. You can always follow a person around until they become unresponsive and then treat them.
- Call 911 and let paramedics use their expertise and (non-physical) coercive authority to invoke implied consent and take patient to the ER.

3.3 Medic/Patient Interactions

Don't make promises you can't keep. Instead of "everything will be okay" say "we are doing everything we can to help you" or "the ambulance will be here soon"

- Never lie to a patient.
- Be respectful of the patient's feelings.
- Never talk about a patient's condition or injury in a pessimistic, hurtful, or scary way, especially in front of her – even if she is unresponsive. (eg. "She's not gonna make it, that's gross, OH MY GOD") Just because someone is unresponsive doesn't mean she can't hear you.
- Help the person, don't take over the person.
- While you are treating someone, interact with them as much as you can.
- Tell them everything you are doing and why. People hate surprises.
- Encourage patients to ask questions. If a patient is asking you questions you don't know how to answer, don't bluff or lie. Say, "I don't know" or "it's how I was trained."

3.4 Confidentiality

Medical information is sensitive, as is other information that might be shared with you as you learn a patient's history, or while talking with patients in emotional distress. This information should not be shared with anyone except other care providers unless the patient gives consent. A patient who says "tell my friend I hurt my ankle!" is giving consent to have only that much information shared with that specific person.

If a patient does not give explicit consent to have information shared, it should be kept private. This includes information about what kind of care you provided to the patient.

The exception is information that has all identifying details removed, and which could not reasonably be expected to reveal the patient's identity. This is how we are able to share medic stories without identifying details.

Keep in mind that, while keeping confidentiality is an important aspect of consent and good medic conduct, your conversations with patients are not privileged according to law. Be careful about making yourself a witness to a patient's illegal activity, as you could be called to testify against them. It's a good idea to remind anyone telling you sensitive information about illegal actions that your conversation is not in confidence.

3.5 Your Privilege: Know it, Check it, De-Naturalize it.

Think about: How might my privilege (as a man, white person, a cisgender person, a person with class privilege, an able-bodied person, a thin person, a citizen, etc.) affect my medic work?

Oppression

Oppression is the act of using power to empower and/ or privilege a group at the expense of disempowering, marginalizing, silencing, and subordinating another group.

Oppression theory is an absolutely essential tool for anyone interested in doing healthcare work. Good medics enable their communities to do good political and community work, and go about that effort conscious of the effects of white supremacy, class exploitation, patriarchy, heterosexism, imperialism, globalization, ageism, ableism, sizism, cissexism, xenophobia, monoculturalism, capitalism, and other systems of oppression.

Intersectionality

Oppression is a theory that seeks to examine the ways in which various socially and culturally constructed categories interact on multiple levels to manifest themselves as inequities in society. Intersectionality is a framework through which to examine how interlocking systems of power affect the most marginalized in society.

Coined by Black feminist scholar Kimberlé Crenshaw in 1989, intersectionality referred to how women of color, and particularly Black women, are impacted by racism and sexism and how those forms of oppression are inextricably linked.

Intersectionality holds that the systems of oppression within society, such as those based on race, ethnicity, gender, religion, nationality, sexual orientation, class, or disability do not act independently of one another; instead, these forms

of oppression overlap and compound each other and affect every level of society.

- Be accountable for your mistakes. Take complaints about your behavior or treatment seriously.
- Say that you're sorry.
- Ask if there is anything that you can do.
- Know that it is not another person's job to explain or educate.
- It is your job to educate yourself and seek out information.
- Ask the person if they want your contact info.
- Be willing to enter mediation.
- Ask another medic for guidance/support

3.6 Activating Emergency Medical Services (EMS)

Throughout this training we will refer to “call 911” as an option when things are beyond your scope. Be aware that the real term is “activate Emergency Medical Services,” which may not be calling 911. In some (very few) areas of this country the EMS system operates off a standard 10-digit phone number. In some areas, there may be no cell phone service and activating EMS may mean driving somewhere to make the phone call. Sometimes activating EMS may mean asking the cop standing near you to please call an ambulance (see next section for more on negotiating with police). When you encounter a **RED FLAG** and need to activate EMS:

Decide if you can step away from the patient to make the call, if it's appropriate to make the call in front of the patient (this is rare), or if you should use a bystander or witness to make the call. In that case, designate someone – a specific person – to call for you. “You, in the blue shirt, please call 9-1-1 and tell them _____, then come back and let me know what they said.” If that person does not return quickly, have someone else call.

Know where you are before you call. Do not get overly excited and call dispatch to tell them all about your patient's RED FLAGS—they can't help us if they can't get to us! Walk to a corner to read a street sign, or ask someone in the crowd where you are.

The patient, even if unresponsive, may be able to hear you. Others in the crowd can also probably hear you. Spread calm. Move out of the patient's earshot and be clear and concise.

Utilize the other medics around you. It is possible that EMS will not come to your patient until the police “declare the scene safe” by their standards, and you may need additional support before that time. Call the other medics at the action, or call the organizers/medic dispatch and coordinate getting in touch with differently trained medics and getting their support.

Throughout the manual RED FLAGS will appear in boxes like this one. RED FLAGS are always going to be transferred to higher care.

3.7 Talking with Police

Talking with police is not the most fun thing we do as street medics. It is sometimes necessary though, for the well being of our patients.

Good police negotiators have the following attributes:

They do not think they “can handle it” or outsmart the police.

They recognize the inherent unfairness and injustices in the situation and are willing to set those aside for the specific needs of the specific patient.

They are calm, straightforward and willing to repeat themselves ad nauseam.

They are willing to give officer’s their legal name.

A state certification is helpful (remember, we’re playing by their rules now).

Remember that police can lie to you, but they have a vested interest in not losing their negotiating power at future actions and are also trying to avoid the bad publicity and lawsuits that accompany the “POLICE LET PERSON DIE AT PROTEST” headlines.

Know what you need before you begin to negotiate.

If the police are holding you in an area and you need a patient taken to the hospital, you are negotiating to get an ambulance in (or get the patient out to a waiting ambulance).

If you are being held and the patient needs to stop being held (panic attacks, weather problems), ask police if the patient, one friend, and a buddy pair of medics can leave.

If you need a patient to be stationary while waiting for an ambulance and the police are trying to clear an area of protesters, ask if the patient, one of the patient’s friends, and a buddy pair of medics can stay until the ambulance arrives. Specify what will happen after the patient is loaded into the ambulance – will the medics be allowed safely out of the area? Will they need a police escort to leave?

When you approach a line of police who are holding an area (or possibly holding you inside an area):

Approach slowly, holding up some form of ID (a certification card, a badge, or something with a cross symbol).

If the cops signal you to stop or back up (possibly by aiming pepper spray or other weapons at you), believe them. Do not keep approaching if it may get you hurt. Do not create a second patient!!

Speak loudly and clearly and state, “I am a [street medic, Wilderness First Responder, EMT,]. I need to speak to someone about a patient. Who can speak to me?” Cops are sometimes under direct orders to not respond to any requests from the crowd. Most cops lack the authority to negotiate with you anyway. Keep moving up or down the line, asking with whom you should talk.

If the cops won’t let you close enough to speak to them, or if they will not produce someone who will talk to you, there are other options:

Go find a legal observer from the NLG (bright green hats!) and take her with you, preferably with a video camera rolling.

Use corporate media (this is their one good use!). Corporate media will like the story.

Call 911 and tell dispatch where you are and what you need.

When you find someone who will talk to you, introduce yourself and restate your qualifications.

Calmly explain that you have a patient with _____ problem who needs _____. When the cop tells you what she can (or can’t) do, ask for a badge number and name or a business card. Repeat what the cop said she would do—“So I’ll bring my patient back here and you’ll let her and her friend leave, right?”

Keep your patient out of sight of the cops, unless they ask to see her. You do not have to let cops “examine” your patient for any reason, but if they want to see her, it may be advisable to bring her into their line of sight.

Be aware that if police let someone out of an area where others are being detained/ arrested, they are likely to search the person to ensure nothing “illegal” is being sent out with her. Tell your patient this before going to negotiate with the police (or the medic that stays with the patient can do this) and consider giving her a safer, private place to dump anything she doesn’t want found in a search.

4.0 Scene Survey

All medical interactions start with a scene survey. We can't medic anyone unless we are safe and we know what's going on around us. There are five steps to the scene survey, and luckily, there is a rhyme to help us remember them.

"Number one, look out for number one,"

"Number two, what happened to you?"

"Number three, don't get any on me!"

"Number four, are there more?"

"Number five, dead or alive?"



1. Look out for Number 1

Your safety comes first. Never create a second patient. If you are injured or incapacitated, you will not only be unavailable to help, but you will need to be attended to as well. When a medic is hurt, their buddy become unavailable to others until the problem is solved. By getting into a situation that gets you injured, you are taking TWO medics away from others. Never create a second patient.

2. What happened to you?

What happened to the patient is referred to as the Method of Injury (MOI) or Nature of Illness (NOI). This is also part of keeping ourselves safe—if something fell on the patient, is it going to fall on you, too? Is the cop who hit the patient still standing next to her?

Beyond our own safety, understanding what happened to the patient helps us narrow down our focus on possible injuries and treatments. Since we cannot diagnose, the best we can do is make good guesses based on what we observe and know, and act accordingly. A fall, for instance, will give an index of suspicion for different injuries than being hit by a car. Early detection of some injuries or illnesses is so important (for example, to the spine or neck) that a high index of suspicion is

encouraged to avert further harm (e.g. spinal precautions for a patient we find on their back behind a ladder). We don't know how far they fell (if at all), but moving them could be very dangerous, so we act as though their spinal column is unstable and have them remain still.

Remember, this is just a quick first look. We will continue with a more detailed assessment after our scene survey.

3. Don't get any on me!

Whatever is on the patient (blood, snot, pepper spray), you don't want on yourself. This is called **Body Substance Isolation**, or **BSI**. Body Substance Isolation concerns avoiding the exchange of bodily substances, of which there are many: blood, vomit, urine, saliva, feces, and more.

We use gloves, goggles or glasses, bandanas or masks as barriers between ourselves and the patient.

- BSI protects the patient from us
- BSI protects us from the patient
- BSI protects the patients from the other patients that we've previously treated

Wear non-latex gloves any time you might have contact with any body fluid. Most medics wear gloves any time they are treating somebody because you never know when someone might vomit or you

might find hidden bleeding. Put gloves on before approaching a patient. Don't walk around with gloves on, since they get dirty or contaminated and then don't help to protect the person being treated. A lot of folks are allergic to latex, and latex allergies range from simple skin irritation to life threatening breathing problems. Non-latex gloves, band-aids and ace bandages are readily available: read labels and do NOT carry latex.

Change gloves with new patients! Do not inadvertently expose multiple patients to chemical weapons or bodily fluids. Remember that gloves are disposable and our health is not. Take your gloves off to go through your kit, to write something down, or to touch anything that can transmit body substances or chemical weapons to another object or a person. Avoid cross contamination!

Store gloves by pairs in small ziplock bags or film canisters, two pairs to a bag if you really need to. Ziplock bags make our kits more organized and protect supplies from chemical weapons.

How to remove gloves safely:

- Use your gloved writing hand to pinch the wrist area of the glove on your other hand.
- Pull away from the skin and toward the ends of your fingers.
- Continue pulling off hand until the glove is off. You should have an inside out glove, with all goo or trash on the inside.
- Ball the removed glove into your writing hand. Using your ungloved hand, slip your index finger between glove and wrist, and pull out and toward fingers until the glove is removed.
- You now have a glove turned inside out within the other glove and hopefully all biohazard on the INSIDE of the gloves.

And then what?

If you have biohazard inside gloves, don't just leave the gloves in the gutter, as lots of folks go through trash on the street for food and recyclable bottles. Anything dripping "biohazard" (body substances) should go in a special biohazard bag. Be responsible and do the best you can with what you have. A glove with some snot or pepper spray on it, inside out and inside another glove, can fairly safely be put in another bag (perhaps with all the other used

gloves of the day) and thrown out. A cloth saturated with blood might need special consideration for disposal.

A word on needles:

NEVER recap a needle, if you don't have a sharps container, try to find a plastic (not glass!) bottle and label as biohazard/sharps container as clearly as possible. Do not put sharps container in regular trash. Do not handle needles unless you have been trained to do so and the situation is appropriate. This training doesn't cover any procedures that will be using needles.

Do not create a second patient! DO NOT GET EXPOSED! See appendix for further information on exposure.

4. Are there any more?

Figure out how many patients there are. If there are more patients than medics standing there, call for additional medics BEFORE beginning treatment.

Look around for hidden patients - there may be people screaming from pepper spray, but the silent patient passed out on the ground is a higher priority.

5. Dead or alive?

Your general impression of the patient is important for a number of reasons. It's one of the first indications of what we may need to do for the patient, or what they are experiencing. Is the patient moving or lying still? The acronym here is LOR, or Level of Responsiveness. AVPU is the acronym to help you remember the levels:

A	Alert: Awake and able to talk to you (alert will get broken down into steps later).
V	Verbal: Not alert, but can hear and respond in some way.
P	Pain (as in responsive to pain): Doesn't respond to verbal stimulation, but responds if pinched
U	Unresponsive: Doesn't respond to verbal or pain stimulation.

5.0 Initial Assessment

The Initial Assessment is a series of steps that we go through at least once with every patient. With a serious patient, we may repeat these steps every 5 minutes. Whether we suspect something serious or not, these steps will always be in the back of our mind and we will return to them at any point necessary, no matter what else we are doing.

The steps are:

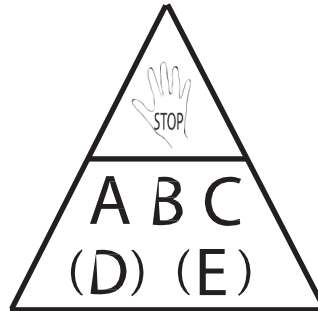
A is for Airway [5.1]

B is for Breathing [5.2]

C is for Circulation [5.3]

(D is for Decision [5.4]

E is for Environment) [5.5]



Our primary considerations as we move through ABC(DE) are life-threatening problems. It is written (DE) because those are problems that may not be immediately life-threatening, but could become so without proper recognition and treatment.

The ABC(DE)'s are called stop-and-fix steps. As we go through each step, in order, we fix whatever problems we find before moving on to the next step. Finding and treating ABC(DE) problems is where a medic can save lives.

Any ABC problem is a RED FLAG and you should activate EMS and utilize the highest-trained medics at the action. Remember, if it's not a life-threatening problem, it is not an ABC problem, and we can (and should) delay treatment of it until we have completely gone through ABC(DE).

5.1 A is for Airway

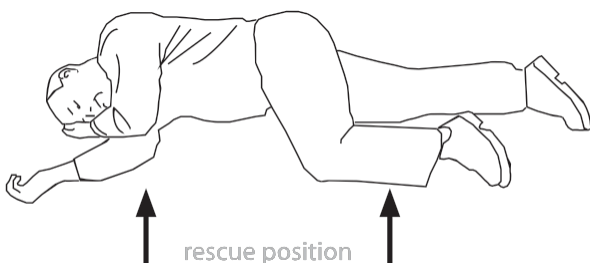
An airway is the most basic life step. Good news—if your patient is talking, then she has an airway!

In a patient who rates either V, P or U on the AVPU scale, the most common cause of airway blockages is the tongue. A head-tilt chin-lift is used to move the tongue out of the way in a patient who can't do it herself.

- Put one hand on the patient's forehead and use two fingers under her chin. Be sure your fingers are not pressing into her trachea! Tip the patient's head back—WAY back! Most people do not tip the head far enough on adults. The patient's shoulders should be affected by the position of the head. Once the airway is "open," move on to Breathing.
- If for any reason we need to leave an unresponsive patient (even for a moment), we will have to put her in the "rescue" or lateral position to keep her airway clear of her tongue and possible vomit. She should be stable, with her head angled downward and to the side.

For a talking patient, all we have to do is make sure she doesn't LOSE that airway.

- Ask, "Is there anything in your mouth?" LOOK in the patient's mouth. Anything (chewing gum, chewing tobacco, dental appliances, broken teeth) can become an airway obstruction. Liquids (including vomit or increased saliva from pepper spray) can also cause a patient to choke.
- Tell the patient to spit and encourage her to lean forward and keep spitting.
- When she confirms her mouth is empty, or when you can see that it is, move on to Breathing.



Abdominal Thrusts

Abdominal thrusts (aka, "Heimlich Maneuver") are a potentially dangerous, but lifesaving technique for assisting a choking patient, who has a **FULLY BLOCKED AIRWAY**. A fully blocked airway means there is no cough, no speech, and no breathing.

Normally part of CPR training, this action should be attempted **ONLY** once the patient ceases the ability to inhale and make noise - **NOT** the patient who coughs loudly or yells "I'm choking, who knows the Heimlich?!!" If the patient can still cough, they should be encouraged to do so to try to dislodge the foreign body.

Once you have introduced yourself and obtained consent, step behind the patient, explaining as you do. Ask them to point to their navel. Then curl one hand into a fist and cup it in the other hand, directly above where they point. Then proceed to thrust your balled fist in and up into their abdomen, asking the patient to try coughing. Firm, rapid "J" movements work best for this (picture touching their navel to their ribcage.)

Before beginning this action, make sure of your footing. Not only can abdominal thrusts be taxing, but frequently patients will pass out in the midst of the process. Remember you can only stop once they breathe again, collapse, or someone of similar/higher training takes over. If they collapse, you will want to be prepared. Place one foot between their legs and your other behind you to brace yourself. If the patient goes limp, walk them down to the floor – often easiest if you sit them down along the way. *Always be careful with a patient's head and neck.*

If a patient has a blocked airway, this is a **RED FLAG**. Activate EMS and find someone certified in CPR in the event that the patient becomes unconscious.

5.2 B is for Breathing

For a patient who is A on the AVPU scale, the next step after ensuring an airway is to check ease and effectiveness of breathing.

First look at and listen to the patient. Patients experiencing breathing emergencies may show signs of difficult or unusually (for the patient) fast, slow, shallow, deep or noisy breathing. They may not be able to speak in full sentences. Confusion and changes in skin color and temperature may also occur.

Ask for consent, then place your hands high on the sides of the patient's ribcage and apply gentle pressure. Ask the patient to take a deep breath and let it out. Move your hands down to the lower portion of the rib cage and have the patient take another deep breath and let it out.

If a patient reports pain or we feel something not normal for the patient, we must expose the injury to determine the extent. Explain to the patient that seeing the wound site is vital to determining the extent of the injury and what the best course of action is.

Difficulty breathing is a challenging problem to fix with limited scope and medical supplies. Have the patient stay in a position of comfort—often this is a tripod position (leaning forward, hands on knees). Many people will naturally “anatomically splint” to help ease rib pain. Your patient may hold her arm

firmly against her chest, or lay on one side. Encourage a position that eases breathing and do not force a patient to move. Keep the patient calm and give encouragement: “you are doing a great job, keep it up, I’m going to stay here with you.”

For a patient who is less than A on the AVPU scale, after opening the airway, CPR protocols of checking for breathing and pulse will apply. Get CPR certified! If a patient is V or P on the AVPU scale, she must be breathing and have a pulse. Monitor her in case that changes and CPR is needed. Having a patient at V or P is a RED FLAG—call 911 and utilize higher trained/ CPR certified street medics.

A patient who is U on the AVPU scale may or may not be breathing or have a pulse. If neither is present, the patient is considered dead, and CPR must be started. (Get CPR certified!)*

A patient who is U but breathing and/or has only a pulse is also a RED FLAG—call 911 and utilize the highest-trained street medics!

*While there is no substitute for the muscle memory and feedback of hands-on training, “hands-only” or “citizen” CPR instruction is now available online through the Red Cross and American Heart Association.

RED FLAGS:

- Signs of pain (watch the patient's face)
- Uneven rib expansion or deflation (one side larger or takes longer than the other)
- Soft spots on the ribcage
- Crepitus (the sound of bone grating on bone)

5.3 C is for Circulation

Circulation has two main parts — pulse and bleeding.

Pulse:

A patient who is anything above U on the AVPU scale has a pulse – done! A patient who is U on the AVPU scale may or may not have a pulse. If this patient does not have a pulse, she is dead and needs CPR (get

certified!*) If this patient does have a pulse, this is still a RED FLAG - call 911 and utilize the highest-trained street medics available. After calling for help, go on with the blood sweep described below.

Bleeding

For a patient who has a pulse (is either A, V, or P, or is U and you have found the pulse), move on to checking for bleeding. Only certain types of bleeding are a concern at this point in the assessment. Remember, ABC(DE) stop-and-fix deals only with life-threatening problems. If we find non-life-threatening bleeding, we will come back to it after our assessment is over.

Life-threatening bleeding is:

- Blood spurting (shooting out in pulses, in rhythm with the pumping of the heart). This signals an arterial bleed. The blood from an artery is bright red because it has just come from the lungs and is highly oxygenated. To slow this type of bleeding, apply direct pressure with something clean and immediately available over the spurt, and raise the

Shock

Shock is a problem of not enough blood getting to vital organs. It is different from the emotional state that can occur following a traumatic experience.

Signs and symptoms (S/Sx) of shock:

- Pale, cool, clammy (PCC) skin
- Sense of impending doom - patient may say, “I feel like I’m going to die!”
- Change in LOR, anxious, restless, disoriented
- Patient may be nauseated, dizzy or thirsty
- Heart rate - rapid and weak or thready
- Respiration - rapid and shallow

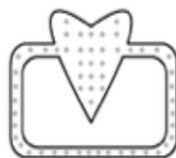
Treatment (Tx) for shock:

- Prevention!!
- Treat the cause – slow the bleeding
- Keep the patient calm
- Keep the patient warm
- Activate EMS, urgently seek higher care
- Monitor closely for further deterioration

area above the level of the heart. Do not remove that first layer, but additional layers can be added if needed.

- Bleeding from the core of the body. To identify this, perform a “blood sweep.” Ask the patient for consent, then run your gloved hands as close to skin level (under jackets, thick sweatshirts,) as possible. Examine your gloved hands for blood after each area of the body. There is no need to check extremities that can be seen. Check the head, neck, trunk and thighs. If bleeding is found, slow it with direct pressure.
- Bleeding may be internal as well as external. We can- not always see internal bleeding, but we can see signs that it is present at a dangerous level. See shock, below.

There are three ways shock can happen:



This is your circulation system in diagram form. It sends oxygen to all your important parts.

A “volume problem” - There is not enough blood to provide organs what they need. This may be because the blood is spilling out onto the ground (or into the body cavity), or it could be the body cannot circulate more blood because of dehydration.



A “pump problem” - The heart, the body’s pump, may cease to function adequately or at all, causing the blood to cease circulating to vital organs.



A “container problem” - Veins carrying blood to the vital organs may swell (dilate) or become leaky. Because the amount of blood no longer fills the veins, they lose pressure and the blood in the veins may pool instead of circulating. This can happen during a severe allergic reaction or with infections.



5.4 D is for Decision

Decision (called “disability” in other trainings) refers to spinal cord injuries. Consider the MOI to decide if it is necessary to take spinal precautions (also called “holding C-spine”).

Mechanisms of Injury (MOI) for spinal injury (remember that these are things that may cause spinal injury, not things that definitely cause spinal injury):

- Falls of more than twice the patient’s height
- Landing on head or neck from any height
- Twisting or whiplash injuries
- ANY patient who is V, P or U on the AVPU scale – the exception being if you saw the patient fall “gently” from a standing or sitting position

Tx for possible 'D-step' problem:

BEFORE asking consent, tell the patient to keep her head still. “Please don’t move your head, I’m worried you might have hurt your neck/back/head, can I put my hands on your head?”

Take hold of the patient’s head as a reminder to keep still. It is best if the patient is laying flat on her back, because the ground acts as a splint, but environmental concerns or other injuries may preclude this position. You can still hold C-spine on a standing or sitting patient!

EVERY question to the patient should be prefaced with, “Don’t move your head.” Remind the patient to not move her head as often as necessary.

When we need to move a patient who is already in C-spine we use specific rolls and other careful, calculated movements to protect the spinal cord. It is possible to do one-person rolls, but two-person rolls are better. With two or more people, the person holding the patient’s head is in charge of the roll and gives a countdown. “We’ll roll her toward Mary on the count of three. Is anyone NOT ready? Okay, one, two, three.”

Once you have determined that there is a MOI for a spinal injury and have initiated spinal precautions on a patient, you may not let go except under certain circumstances:

- The scene becomes unsafe for you to stay
- A person with higher training takes over

- It is medically necessary—remember that D comes AFTER A, B and C. These always have priority over D. If you must let go of a patient’s head in order to clear her airway, do it! If you must let go of a patient’s head to stop bleeding, do it! Do not let go of a patient’s head in order to complete a head-to-toe exam (step F, which comes later).

A person with an MOI for a spinal injury has a RED FLAG and must be transported via ambulance (to ensure continued immobilization of the spine) to a hospital. Utilize the highest-trained medics available to you on the street—certified WFR’s and some others can do a spinal exam and may be able to release the patient from C-spine.

What if the scene becomes unsafe?

There may be a time when you are holding C-spine on a patient who is lying down and the police attempt to clear the area with threats of arresting anyone who stays. This is when your medic police negotiator comes in. This person needs to explain to the commanding police officer (out of earshot of the patient) that you have a potentially seriously injured person here who needs to be transported to the hospital via ambulance. Ask for the patient, the patient’s friend, and two medics to be allowed to stay where they are until EMS can take over the patient, and specify that the medics will then rejoin the crowd.

Remember that every situation is different and no amount of writing or teaching can give “The One Correct Answer” for every possibility. If we have decided that our patient has an MOI for a possible spinal injury and we begin to hold C-spine, that decision cannot be reversed based on the changing scene. If the patient needed to be in C-spine before the police showed up she needs to be in C-spine after the police show up!

5.5 E is for Environment

Ongoing scene assessment: Look out for number 1!

When we consider environment it is good to ask ourselves, “Is the situation surrounding my patient right now acceptable, or is it going to do harm to myself, my patient, or other people?”

If the answer is yes, we need to move ourselves and/or the patient immediately.

Ongoing Scene Survey considerations:

- Is the scene still safe?
- What is the feeling of the crowd? Are people calm?
- Who do we know? Who does our patient know?
- What’s happening next? Is a march about to start, or are the police ordering folks to leave?
- What are the cops doing? Where are they, how many?
- Can we send a scout to observe the crowd, the cops, and confirm or dispel rumors?
- What supplies do we have? What supplies are around us?
- What is the weather doing to our patient?
Being too hot, too cold, or not having enough water or food can all have drastic effects on the patient. We will learn more about weather in specific injuries/illnesses later.

There are several ways a crowd can be useful in the care of a patient. A crowd can be used to make a privacy circle, both to prevent the patient from being stepped on and to block the view of people and cameras from the patient. Ask people to form a

circle around the patient, at least 5 feet away, facing out. Folks should stand shoulder to shoulder, linking arms if necessary.

The privacy circle can be used to pass messages to the rest of the crowd. “Privacy circle, repeat after me - The ambulance is coming. We need to clear a path.”

Even without a privacy circle, the voice of the crowd can be used to spread messages. “If you can hear me, repeat after me/ I need everyone/ to take five steps back.”

With crowds familiar with the Occupy movement, the phrase “Medic Mic Check!” has also worked well to encourage the crowd to spread a message.

Having completed steps A-D, if we have found any problems or potential problems with our patient that were not visible before, we EXPOSED them in order to stop-and-fix. Now that we are considering the Environment, we want to make sure our patient gets covered back up and protected from both the weather and the crowd.

This is also the time to get our patient off the ground. There will rarely be a time when the ground is the ideal place for the patient. After checking for ABCD injuries and considering the entire scene again, get something between the patient and the ground. If there is a D-step problem, use a log roll to put the patient on her side and put a mat, a few jackets, or whatever you have, on the ground and roll the patient back onto it. If your patient is mobile, move her onto a barrier or into a chair.

5.0 Continued - Secondary Assessment

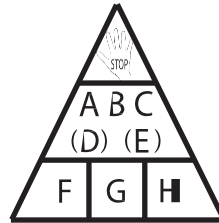
The following steps are to find and treat not-immediately-life-threatening problems and injuries. As you move on to them, keep the ABC(DE)'s in mind, and if a problem in one of those areas comes up, abandon where you are and go back to it. Otherwise, problems found in the next steps are not treated immediately. Finish all of the following steps before providing treatment for what you find.

These steps are:

F for Full Exam (also called Head to Toe) [6.1]

G for Get Vitals [6.2]

H for History [6.3]



These steps are not ranked in order of importance as ABC(DE) are. Because we will finish these steps before providing treatment, we may change the order of the steps, as long as all are completed. When dealing with trauma the steps should be done as Full Exam, Get Vitals, then History. When dealing with an illness, the steps should be done as History, Get Vitals, Full Exam. We will talk more about this when we talk about treatments for specific injuries/illnesses.

5.6 F is for Full Exam

A Full Exam, more commonly called a “head-to-toe,” is a way to physically identify other injuries on a patient. Each time you practice a head to toe, say each part out loud; this will help you remember your system and is helpful to your patient so she knows what is coming next. Be sure you have proper consent and your patient is comfortable with the exam.

Following the same system each time you do the exam is important for building muscle memory and ensuring no parts are left out. However, if a patient has a “distracting injury,” take a look at that first to determine the extent, then go back and start the exam at the head.

Look, listen, and feel for anything on a patient that wasn't there before the injury: bruising, bleeding, swelling, pain, tenderness, deformities, crepitus, or unusual hardness or softness—anything out of the ordinary. Use firm pressure, like a strong massage. You want to feel that bones are intact. As injuries are found, they should be exposed so they can be examined, but not treated until the end of the FGH steps. Be sure to have consent to remove or cut the patient's clothing, but be sure to look at each injury.

Head, face and neck:

Carefully remove hats, helmets, sunglasses, gas mask. Try to keep track of the patient's things by putting them in a bag or giving them to a friend to hold. Run your fingers through hair, palpating the skull. Examine the face, pressing on bones. Check eyes, nose and mouth. Check in, behind, and below the ears. Feel along the muscles and bones of the neck. Check for tracheal alignment. Check for medical ID tag.

Shoulders:

Check one shoulder at a time. Check collarbone, then make a shoulder sandwich.

Chest:

Spread hands over sides of chest wall. Check for instability and/or asymmetry on inhalation- once high on the chest, once low on the chest. Ask the patient to take a deep breath on both checks. Press hand on center of sternum.

Abdomen:

Press with flattened fingers on each of the four quadrants. If patient is responsive, look at her face while you are doing this to assess for tenderness/pain or guarding.

Pelvis:

With hands cupped on the hipbones, press inward, then downward. (Downward meaning posteriorly—toward the patient’s back. With your patient lying on her back, that would be toward the ground.) If there is any pain or movement on the inward, DO NOT press down!

Genitals:

Ask, “Is there any reason to check your genitals?” Unless the patient says yes, move on.

Lower Extremities:

Check one leg at a time with hands encircling the extremity. Check from hip to toes. Check toes on both legs at the same time for **CSM - Circulation, Sensation, Movement**. Feel for warmth, ask, “Which toe am I touching?” and have patient push down and pull up against your hand. Compare the sides. Check for medical ID tag.

Upper Extremities:

Check one arm at a time with hands encircling the extremity. Check from shoulder to fingers. Check fingers for feel for warmth, ask, “Which finger am I touching?” and have patient squeeze your fingers. Check for medical ID tag.

Spine and Back:

If the patient is being held in C-spine, do a two-person roll to check the back. If there was no MOI for C-spine, have the patient sit up. Palpate the entire length of the spine from the base of the skull to the beltline. Press on each side of the spine at the shoulder, lower rib cage, and flank with the flat of your hand. After this check, roll the patient back onto her back.

Record the findings of the head to toe. Be very specific about where any injuries found (which side of the patient, which side of the limb), how large, what shape, and anything else of note.

Remember that this is not a stop and fix exam—find the injuries, note them, and move on, reassuring the patient that you will come back and take care of these things in a moment.

5.7 G is for Get Vitals

Taking vitals is an important skill because they tell us what is going on in a patient’s body. Monitoring changes in vital signs over time gives us the most information about a patient.

Tools needed:

- Watch with second hand/second counter
- Paper and writing utensil
- Every set of vitals should be recorded, along with the TIME the set was taken.

Level of Responsiveness (LOR):

This is the most important vital sign. We made a first observation during the Scene Survey and continue to monitor it throughout the entire treatment.

At this point, we have time to be more specific about where the patient is on the AVPU scale. Be descriptive if the patient is lower than A – “patient moaned when asked if she could hear us,” or “patient pulled arm back when pinched.” Here ‘A’ actually reads as “Alert and Oriented,” which we assess at 4 levels using these questions:

1. Can you tell me your name? (person)
2. Do you know where we are right now? (place)
3. Do you know what time of day it is? (time)
4. Can you tell me what happened? (events)

The scale is AVPU:

Alert & Oriented to Person, Place, Time & Events - AO X 4
Alert & Oriented to Person, Place and Time - AO X 3
Alert & Oriented to Person and Place - AO X 2
Alert & Oriented to Person only - AO X 1
Responds to Verbal stimulus - V
Responds to Painful stimulus - P
Unresponsive - U

The order of these questions may seem arbitrary, but actually does matter, and makes sense. Patients will generally forget what happened and when before they forget where and who they are.

Note: people may not want to share their “real” name or what they were up to when they were injured. What is important is that they know, not that they tell us. Remember also that every person has a different normal. Some people may be in their normal but unable to respond appropriately to a simple request. Ask lots of questions of the patient and the patient’s friends to try to determine if this is normal for the patient, but remember (at this point) any information you can’t get in a matter of seconds isn’t necessary. Make sure that you monitor and reassess LOR, looking for changes. Some conditions may cause noticeable drops in LOR in a few minutes.

RED FLAGS:

- The patient is currently lower than AO X 3
- The patient was, at any point, V, P or U – even if “fully recovered”
- The patient’s AVPU level DROPS at all, even from AO X 4 to AO X 3

Heart rate (HR):

Feel radial (wrist) pulse for 15 seconds and multiply by 4 to get beats per minute.

Note the rhythm - regular or irregular.

Note the quality - strong ('normal'), bounding (too strong), weak

Respiratory Rate (RR):

Count breaths for 15 seconds and multiply by 4 to get breaths per minute. Do not tell the patient you are counting breaths – let her think you are still taking pulse.

Note rhythm – regular or irregular.

Note quality – unlabored ('normal'), shallow, deep, labored, wheezy.

Skin (SCTM):

Color - pink, pale, ashen, red, blue. Use non-pigmented areas like inner lips, palms, or nail beds.

Temperature - cool, warm, hot. With consent, feel under the shirt on the shoulder.

Moisture - dry/moist/wet (on unbroken skin, not mucus membranes)

Pupils:

Should be Equal, Round, and Reactive to Light (PERRL). You do not need a fancy mini flashlight to check your patient’s pupils (although it is fun and makes you look like a doctor). In daylight, ask your patient to close her eyes, and use your hand to create a shadow over her eyelids. Wait at least 10 seconds, then remove your hand and have the patient open her eyes and look at you. This is a yes or no question.

Average Range Vitals:

LOR AOx4
SCTM Pink / Warm / Dry
HR 60 - 100 / Regular / Strong
RR 12 - 20 / Regular / Unlabored
Pupils: PERRL

You can take some sample sets of vitals here:

Time:	_____	_____	_____	_____	_____	_____	_____	_____	_____
LOR:	_____	_____	_____	_____	_____	_____	_____	_____	_____
Skin:	_____	_____	_____	_____	_____	_____	_____	_____	_____
HR:	_____	_____	_____	_____	_____	_____	_____	_____	_____
RR:	_____	_____	_____	_____	_____	_____	_____	_____	_____
Pupils:	_____	_____	_____	_____	_____	_____	_____	_____	_____

5.8 H is for (SAMPLE) History

S	igns and Symptoms (S/Sx) "Signs" are what we as medics observe; "Symptoms", what the patient feels. Suspected MOI for trauma: signs should surface primarily in the Head-Toe and Vitals; remember to ask about all symptoms in addition to chief complaint NOI (the patient seems to suffer from something illness-related); we refer to OPQRST [5.8b] to characterize symptoms
A	llergies What you are allergic to? What happens when you are exposed? Is it possible you were exposed today? How long ago you were last exposed?
M	edications Prescriptions Over-The-Counters, Herbs and supplements Recreational substances (+ alcohol) Also ask: When did you last take them How much/often? What you are taking them for If they carry them with them, where?
P	ast Pertinant History Seeing a doctor for anything (conditions)? Who? Contacts? Had any relevant surgeries/injuries/illnesses previously? Being treated for? (currently or recently) Pregnant?
L	ast In/ Last Out When and what did they last eat/drink? Are they peeing?; Qualities (eg. color, pain), frequency, unusual characteristics Same with Pooping, Vomiting
E	vents Leading Up To The Incident What happened before the patient fell? (Did she feel dizzy? Was she running from bees, to which she is allergic?) How has the patient felt today? Try to get full picture of what is going on.

SAMPLE and OPQRST are handy acronyms that will help you remember the steps for a secondary assessment. Sample is more useful for assessments that are focused on determining the NOI (Nature of Illness), where OPQRST is more useful for assessing MOI and pain.

5.8.1 SAMPLE

A SAMPLE history involves asking all of these questions in an effort to learn as much as possible about what is going on with your patient. Taking a good SAMPLE history is critical in finding the unknown or seemingly irrelevant issues your patient may be facing. Your patient's chief complaint may be a distracting traumatic injury, but asking the questions in the table to the left will help you catch (for example) their history of unmanaged diabetes, or the fact that they have eaten nothing for three days.

O	nset When/how fast it began What were they doing when it started?
P	rovokes/Palliates What makes it feel better? Worse? Anything they think might have triggered it
Q	uality of the Pain Burning, stinging, sharp, dull, aching. Get the words from them without prompting (open-ended is best)
R	egion/Refers/Radiates Where/how large is the region experiencing pain Does it radiate (grow), refer ("jump") to other/larger area? to shoulders, back, neck, arms Palpation & S/Sx may provide clues to source or epicenter Some common referrals may suggest specific conditions (eg. angina/heart attack)
S	everity On a 0-10 scale with 0 being no pain and 10 being the worst pain the patient has ever experienced. (Find out what 10 is: If a hangnail is the worst pain they can imagine; 8 may not be so bad. Nerve pain from a torn disk = serious) If they won't play your game get the words they use ("really bad," "sorta bad," "not too bad" etc.)
T	ime Constant or Intermittent Use to track changes in vitals and SAMPLE / OPQRST

5.8.2 OPQRST

OPQRST is a way that you map and understand your patient's experience of pain/discomfort. You want to know as much as possible about it.

Many of the OPQRST questions are useful for an NOI assessment.

For example, your patient is experiencing a very bad headache. An example set OPQRST answers for this patient might look like this:

O: Very sudden, yesterday

P: Not moving/ sleeping

Q: Dull, aching, throbbing

R: Pain is making nauseous

S: 9, like a serious concussion from past

T: Constant as of dinner time yesterday

So, that's the Initial and Secondary Assessment. This is the foundation of everything we do as medics. We'll be practicing it with every role-play we do in this training. Remember that the ABC(DE)'s are stop-and-fix steps and should be continually monitored throughout the entire interaction with our patient. FGH should all be completed before beginning any treatments or interventions ('I').

5.9 I is for Interventions

This is any action we take to treat, council, or evacuate the patient. This will often be transference of care to a person with more or specialized training. Before we go on to our many Interventions, don't forget to document everything you have learned or done. The next section is J where we will produce documentation of interventions and assessment.

5.10 J is for Jot it Down

While one medic is taking vitals and interacting with the patient, the other can be writing down information. Some people carry notebooks, while others use SOAP notes.

SOAP stands for Subjective, Objective, Assessment, and Plan – basically write down what the patient reports, what you observe, assessment including vitals, and what treatment was used. A sample SOAP note is below. We highly recommend that for now you make your own SOAP notes in order to help you remember all the different parts that go into one or utilize the SOAP notes in the appendix. For the purpose of this training your SOAP notes can be a cheat sheet for the entire assessment. You can draw the triangle on it, and write out the full meaning of each letter in SAMPLE, OPQRST and the vital signs if it helps you remember.

<p><i>Subjective: age, sex, MOI, NOI, C/C</i></p> <p>Age/sex: _____</p> <p>MOI: _____</p> <p>C/C (Chief complaint in patient's own words): _____</p> <p>_____</p> <p>_____</p> <p><i>Objective: vitals, focused exam, sample history</i></p> <p>Time: _____ _____ _____ _____ _____</p> <p>LOR: _____ _____ _____ _____ _____</p> <p>Skin: _____ _____ _____ _____ _____</p> <p>HR: _____ _____ _____ _____ _____</p> <p>RR: _____ _____ _____ _____ _____</p> <p>Pupils: _____ _____ _____ _____ _____</p> <p>BP: _____ _____ _____ _____ _____</p> <p><i>Full Exam: Location of pain, tenderness, & injuries</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><i>SAMPLE History</i></p> <p>Signs/Symptoms: _____</p> <p>Allergies: _____</p> <p>Medications: _____</p> <p>Past pertinent history: _____</p> <p>_____</p> <p>Last in/out: _____</p> <p>Events: _____</p> <p>_____</p> <p><i>Assessment (problem list):</i> _____</p> <p>_____</p> <p>_____</p> <p><i>Plan (for each problem:)</i> _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p style="text-align: center; font-weight: bold; margin-top: 20px;">MONITOR PATIENT</p>
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6.0 Trauma

6.1 Wounds

Broken skin of any sort: abrasions, cuts, avulsions (skin flap).

RED FLAGS:

- Anything gaping more than ½ inch - consider the necessity of going to the ER for stitches.
- All amputations (something cut off completely) or circumferential injuries (an injury that goes all the way around a body part, such as finger or limb) should go to the ER.
- Impaled objects – even small ones.
- Cuts to the face (high risk for scarring, discuss with patient).
- Note that these situations may not require ambulance transport –it may be fast enough to take the patient in a car. For puncture wounds be aware of the higher risk of infection, likely need for tetanus shot. and seek further attention.

6.2 Burns

Burns occur when the skin receives more energy than it can handle. This energy comes in many forms – sunrays, heat, steam, chemicals (including pepper spray), and others.

Tx for minor burns:

Stop the burn! This may mean using cold, cool, or running water (not ice), removing the patient from the sun, or removing the chemicals causing the burn.

Evaluate the size of the burn – if larger than 5% of the patient’s body (which is 5 times the size of the patient’s hand), is a circumferential burn, or is on the face, hands, feet or genitals seek medical attention.

Remove anything constricting from the area of the burn, such as jewelry or watches, which can interfere with circulation when the area swells.

Tx for minor wounds:

1. Stop the bleeding
2. Clean by forcefully flushing with clean water or saline (this may restart bleeding, use clean supplies to re-stop the bleeding)
3. Consider applying antibacterial salve or oil.
4. Discuss available options with your patient and be cautious for allergies when using anything containing sulfa drugs (such as “triple antibiotic ointments”). See the herbal aftercare section for more detail on alternatives to over the counter antibiotic creams and ointments.
5. Cover with clean gauze and tape or other form of bandage.

Discuss aftercare instructions with the patient including how to keep the wound clean and how to reapply bandage

RED FLAGS:

There are a lot of rules about burns using percentages of the body and comparing the severity of the burn (superficial, partial-thickness, or full-thickness). An easier way to remember when a burn should be seen in an ER is the “OMG!” rule. If we look at a burn and think, “OMG!” it should probably go to an ER.

This includes burns that are:

- Black or white in the middle
- On faces, hands, feet or genitals
- Larger than 5 times the patient’s hand
- Circumferential (go all the way around a limb or digit)
- Burns on the very young, very old, or very susceptible to infection

Consider use of soothing agent or can be treated similarly to open wounds (if the skin is blistered or broken) once the cause of the burn has been stopped.

Give patient aftercare instructions including attention to hydration and keeping the area clean. Pain medication may also be necessary.

6.3 Musculoskeletal Injuries

We do not have X-ray vision. Musculoskeletal injuries are very common, and it can be very difficult to tell the difference between a fracture and a strain. For the sake of this training we differentiate between injuries the patient can use, and injuries the patient cannot use.

6.3a Usable Injuries (sprains and strains)

Common S/Sx:

- Swelling
- Pain
- Reduced range of motion
- Reduced CSMs

RED FLAGS:

Any unusable injury other than to a digit (finger/toe). And even an unusable digit can be a RED FLAG if your patient is concerned

6.3b Unusable Injuries (Fractures, severe sprains, dislocations)

Common S/Sx:

- Pain
- Bleeding
- Swelling
- Deformity or dislocation
- Diminished CSM
- Symptoms of associated nerve damage:
 - Numbness
 - Paralysis
 - Tingling
- Patient will often report hearing or feeling a “break” and report “I think it’s broken.”

Tx for usable injuries:

RICE for 24-48 hours

Rest: Reduce or prevent movement

Ice: 20-40 minutes with a well insulated ice pack (never directly apply frozen things to the skin!) followed by 15-20 minutes with out an ice pack. Reduce time with ice as swelling lessens.

Compression: Wrap injured site with an ace bandage (Check CSM before/after!) If you have been trained in splinting (not part of this training), apply the appropriate splint.

Elevation: Elevate to resting position above the heart to reduce swelling.

Continue to RICE and monitor for improvement. Expect the condition to worsen over the first 24 to 72 hours, but if it continues to worsen beyond that time- frame or if at any point the injury becomes unusable or CSMs are diminished, seek further care.

Tx for unusable injuries:

1. Seek higher trained medic if possible. Act within your scope!
2. If site of injury is obviously deformed and injured, activate EMS.
3. Monitor CSMs
4. Monitor for shock
5. If you have been trained in splinting, splint for transport/immobilize after “making it look like it did before the injury” and seek further care immediately.
6. Consider C-Spine precautions, if MOI is strong enough to break bone patient could be at risk for spinal injury

6.4 Head Trauma

What is a Head Trauma?

- Whenever someone has a blow to the head:
- From a fall - From how high? How did they land
- On what (kind of surface) did they land?
- From a blow - From what kind of object? Angle? Blunt or sharp? Soft or hard?
- From a sudden acceleration/deceleration - Whip-lash? How fast did it happen?

Types of Head Trauma

- *Open* – Visible damage to skin, skull, brain, and/or casing. May be minor or very serious
- *Scalp* – external laceration; may look really bloody because there are a lot of capillaries in the scalp; treat like other lacerations, but care should be given to protect vital centers (brain, spine, etc)
- *Closed* – Little or no visible bleeding, but this can be very dangerous as brain swelling and/or bleeding can damage parts of the brain that control vital life functions. Evaluating and controlling the damage requires special equipment.

RED FLAGS:

- Decreasing LOR, or LOR < AOx3
- Unequal pupils
- Loss of responsiveness at any time
- D.I.C.C. head – Disoriented, Irritable, Combative, Coma
- Vomiting
- Seizure
- HR decreasing and bounding
- RR erratic and shallow.

Common S/Sx

If a patient exhibits signs or symptoms of a head injury, get help immediately!

- Loss of responsiveness (even briefly)
- Obvious deep cuts or tears in scalp, protrusion of bone or brain matter

- Reduced or decreasing LOR (Level of Responsiveness--AVPU) -- DICC-head
- Headache, Amnesia, Seizure
- Vomiting: especially if periodic, projectile or for an extended time
- Dizziness: Visual changes - seeing stars, blurred vision
- Bleeding: especially from ears and/or nose. May be mixed with cerebro-spinal fluid
- Bruising: bumps, deformity
- Battle's sign: (bruising behind ears), Raccoon-eyes (bruises under eyes)
- HR (Heart Rate): decreases and bounds. This is a late sign. This person needs critical care immediately!
- RR (Respiration Rate): - hyperventilation and erratic breathing. This is a late sign. This person needs help immediately!
- Skin: Warm and flushed

Tx for head injuries:

Anyone with head trauma has a high possibility of C-spine injury, so always immobilize head and spine. Elevate upper body at approximately 30 degrees / several inches to discourage brain swelling.

1. Do NOT put direct pressure on injury site (including ground); use donut bandage if you know how
2. Should be seen by a health care professional
3. Most symptoms develop within 1-6 hours, but monitor for 12-24 hours. Don't let her sleep through that time, wake up every 2 hours and check for LOR. If LOR decreases or if signs and symptoms get worse, go to emergency room immediately.
4. Lots of possible concussion patients don't want to go to the hospital, so aftercare instructions to friends who will be around are essential.
5. Avoid pain medication for 24 hours if not going to a healthcare professional because it may mask symptoms or increase intracranial (inside the head) bleeding.

7.0 Weather-Related Illness

7.1 Dehydration

Dehydration is one of the most common illnesses we see. You are probably dehydrated right now.

S/Sx:

Dry skin, especially noticeable on lips
Thirst
Loss of appetite
Flushed skin
Dark urine
Fatigue
Lightheadedness

Tx:

Best is prevention: Drink and dispense LOTS of water (too much can make us pee, though...)
Rest – stop losing water!
Begin rehydration with water and/or rehydrating solution (water mixed 50/50 with fruit juice with a small amount (a “pinch”) of salt added, Gatorade type drink, a small amount of snack food with water)
Aggressively rehydrate for at least 2 hours (.5-1L of water per hour)
Monitor for heat exhaustion, stroke, or any possibly related or masked symptoms/conditions
Keep patient cool and calm.

7.2 Heat Exhaustion

Heat exhaustion happens when it's hot and folks don't get the water that they need.

S/Sx:

Skin can be PCC or flushed
Heat syncope (fainting and/or dizziness)
Nausea
Fatigue
Thirst and decreased urine output

Patient's temp. stays below 105F
Heat cramps

Tx:

Give water or rehydrating fluids
Rest in cool, shady spot with circulating air
Monitor for shock symptoms
Rest until symptoms subside

7.3 Heat Stroke

Heat stroke happens when the body is no longer able to cool itself due to extreme heat, exertion, and/or ongoing medical issues.

S/Sx:

LOR changes
Hallucinations and seizures
Uncoordinated movements, falling down, stumbling

Skin is red, HOT and dry or moist. Sometimes pale.
Patient's temp ABOVE 105F

Tx:

Aggressive cooling (spray with water, fan patient)
Monitor for relapse
Considering severity/recovery time, possibly transport to ER

7.4 Hypothermia

The lack of heat and the body's decreased ability to produce and retain heat.

S/Sx:

- The patient will first report feeling chilled or “freezing,” but eventually stop feeling cold.
- Irritability
- “The Umbles” The patient mumbles, stumbles, fumbles and grumbles.
- Fatigue and apathy towards the situation.
- Patient will have blue or white skin around lips and eyes.

Tx:

- Prevention! When people feel cold that is the time to prevent hypothermia.
- Keep them moving!
- Feed them, especially warm, carbohydrate-rich foods; warming herbs (eg. ginger, thyme)
- Seek shelter, change the environment around them if possible. Changes in clothes should be considered as well.
- If the patient's LOR drops seek emergency medical care immediately.

Urban Hypothermia

Urban Hypothermia occurs when the cold has been mild but prolonged. It is often seen in houseless populations where the weather is wet and “cold” (slightly above freezing) for weeks at a time. One study of 157 deaths from cold showed that 50% of those deaths occurred while the temperature was between 32 and 41 degrees Fahrenheit (0 to 5 degrees Celsius). When working with patients in typical wintertime PNW weather it is important to keep in mind what sort of medium-term (days-weeks) exposure to the weather this person has had, and to be prepared to treat for hypothermia even in temperatures in the low 40's.

RED FLAGS FOR COLD RELATED

- Lowered/Dropping LOR

RED FLAGS FOR ALL HEAT RELATED

- Altered LOR (even AO X 3) with S/Sx of heat illness

8.0 Illness

8.1 Seizures

A seizure is a temporary alteration in behavior or responsiveness, which is typically characterized by unresponsiveness and a generalized severe twitching of all the body's muscles, that lasts several minutes. This type of seizure is commonly called a generalized seizure. Another type of seizure is called an absence seizure, which is characterized by a brief lapse of responsiveness in which the patient seems to stare and not respond to anyone, possibly performing a repetitive action (lip smacking, brushing hair) that the patient was doing before the seizure began. Other presentations are also possible.

Causes

Epilepsy - Epilepsy is congenital, which means the patient was born with the condition.

High fever - Usually seen in small children, these are called febrile seizures.

Structural - The physical structure of the brain is affected. This can be from a tumor, infection, scar tissue from an old injury, head trauma, or a stroke.

RED FLAGS

- A first-time seizure, no matter the suspected cause (head injury, fever)
- A seizure following a head injury (even if it is not a first-time seizure)
- A seizure accompanied by a high fever (even if it is not a first-time seizure)
- Repeated seizures. Some patients normally have two seizures in a row or within a brief time and do not need advanced care for that. However, any patient who has three seizures in a short period of time should be transported to an ER.
- A seizure that lasts longer than 5 minutes.

Metabolic - The physiology of the brain is affected. This can be from hypoxia (lack of oxygen), hypoglycemia (lack of sugar in the blood), poisoning, drug overdose, or withdrawal from a chemical such as alcohol or medication.

S/Sx:

A patient will often experience a warning prior to the seizure, which is called an "aura." The patient may notice a funny smell, or feel dizzy or weak. Patients who have a history of seizures may have time to warn people around them that they are going to seize and may lay themselves down in a safe place.

The seizure may have the following characteristics:

- Sudden loss of responsiveness
- Chaotic muscle movement and tone
- Apnea (lack of breathing)
- Bladder or bowel incontinence
- Muscle spasms lasting 1 to 3 minutes
- Raised heart rate
- Hyperventilation
- Intense salivation

The seizure will be followed by a postictal state with the following characteristics:

- May last 5 to 30 minutes, sometimes longer
- Patient is Unresponsive at first and gradually moves up through the AVPU scale, including becoming awake but disoriented and dazed.
- Fatigue

Tx for seizures:

- Do NOT attempt to hold her still
- Do NOT attempt to put anything in her mouth!
- Protect her head – put a blanket, coat, your arms under her head without trying to stop it from moving.
- Keep the area around her clear, moving objects if necessary

- Form a privacy circle around her and wait for the seizure to stop.
- Ask her friends for a sense of history — has she seized before to their knowledge? Did she suffer head trauma today? If you hit a RED FLAG at this point, activate EMS immediately.

Aftercare

Recognize that the patient will have a postictal phase, which will start with Unresponsiveness. Monitor ABC and consider DE. Note that a seizure alone is not a MOI for a spinal injury (unless coupled with a fall or other MOI for spinal injury) so you do not have to hold C-Spine, although it will not do harm to the patient after the seizure has ended.

If the patient has lost control of bladder or bowel function try to maintain privacy and get her some clean clothes.

As the patient moves into a state of responsiveness, we can begin taking a SAMPLE history, but remember that a patient who is AO X 2 cannot appropriately answer questions about the day's activities such as Medications taken or Last ins/outs. Wait until the patient is AO X 3 and then reconfirm any information you have already gotten.

The patient may never be AO X 4 - she may not have any memory of the beginning of the seizure. Even a patient who has a history of seizures may forget that she has had one, and this may cause her concern as to why strangers are taking such an interest in her. Be calm and understanding, and without inducing panic, explain that she has had a seizure and you are here to help.

A patient with a history of seizures will be able to tell you what she normally does after a seizure, which probably includes a lot of rest. She will probably be un- able to transport herself home; arrange transportation for her and make sure she has a trusted friend to check in on her.

8.2 Diabetes

Diabetes refers to a condition wherein the body's ability to metabolize simple carbohydrates (glucose, which is sugar) is impaired. The main problem in diabetes is the lack or ineffective action of insulin, which is a hormone produced by the body to aid in the metabolism of glucose. Insulin is sometimes called a "cellular key" because it "unlocks" the cells to allow glucose in to them. There are two types of diabetes:

Type I Diabetes, also called insulin-dependent diabetes, refers to people who do not produce insulin at all. This generally begins in childhood, although it can begin in adults as well.

Type II Diabetes usually presents later in life and is sometimes called non-insulin-dependent diabetes. People with Type II diabetes may produce inadequate amounts of insulin, or may produce ineffective insulin. Some people with Type II diabetes do take insulin, but most manage it with diet, exercise and non-insulin oral medications. Diabetic emergencies are caused by either too much or too little insulin in the body.

Insulin Reaction (or Insulin Shock)

This condition occurs when there is TOO MUCH INSULIN in the body. This condition rapidly reduces the level of sugar in the blood and brain cells suffer.

Insulin reaction can be caused by failing to eat, by taking too much medication, by heavy exercise and by emotional factors.

S/Sx:

- *FAST* onset (minutes or hours)
- Change in LOC
- Dizziness, Headache, Hunger
- Weakness
- Fast breathing and pulse
- Vision difficulties
- Sweating
- Numb hands or feet

Diabetic Coma

This condition occurs when there is TOO MUCH SUGAR and too little insulin in the blood and body cells do not get enough nourishment.

Diabetic coma can be caused by eating too much sugar, not taking prescribed medications, stress and infection.

S/Sx

- SLOW onset (days)
- Drowsiness, Confusion
- Deep and fast breathing
- Thirst
- Dehydration
- Fever
- Change in LOR
- Peculiar sweet or fruity-smelling breath

Tx for diabetic emergencies:

Looking for the signs and symptoms listed above will help to distinguish the two diabetic emergencies. In addition, if the patient is responsive, you can ask two very important questions that will help determine the nature of the problem:

- “Have you eaten today?” and
- “Have you taken your medication today?”

A patient who has eaten and not taken her medication may be going into a diabetic coma. A patient who has not eaten and has taken her medication may be going into insulin shock.

Because of the faster onset of insulin shock, it is the more critical emergency to treat. If we can't tell which condition the patient is suffering from, either because she is so disoriented we cannot get a clear answer, or if she is unresponsive and not wearing a medical alert tag or it does not provide enough information, we treat for insulin shock by giving sugar.

Wait – can't that do harm? What if we're wrong – what if she is going into a diabetic coma? Won't giving sugar make that worse?

Yes, but only mildly so. Insulin shock is both more common and more dangerous (because of the faster onset; both conditions have an end result of death) than diabetic coma. Also, there is more room for error on the side of having too much sugar. A “normal” blood

glucose (sugar) level is between 80 and 120 mg/dL. Insulin shock occurs at 40 mg/dL, while serious complications from diabetic coma do not occur until 400 mg/dL. Without the numbers involved, this means that insulin shock occurs when a body has half a normal level of blood sugar; diabetic coma occurs when a body more than triples the normal level of blood sugar. Therefore, giving sugar may not help if the patient is actually going into diabetic coma, but will not do significant harm.

A responsive patient can be given sugar in many forms. A soft drink, candy, fruit juice or whatever is available quickly. An unresponsive patient can be given glucose gel BY A MEDIC TRAINED TO DO SO. Putting anything in an unresponsive person's mouth (where it can potentially cause an Airway obstruction) is beyond the scope of this training. A Wilderness First Responder and some others are trained to do so, but only under certain conditions. Activate EMS and utilize higher-trained medics if you are treating an unresponsive patient for diabetes.

RED FLAGS

- An unresponsive patient (no matter the suspected cause)
- A diabetic patient lower than AO X 2 on the AVPU scale who does not improve within minutes of being given sugar

Prevention of Diabetic Emergencies

A patient eating and taking her medication as prescribed can usually prevent diabetic emergencies. However, just because a patient can usually prevent a diabetic emergency doesn't mean that we should judge or criticize her for not doing so. People have many reasons for doing or not doing things to keep them healthy, and our job is not to police those actions but to treat the problems that arise.

Aftercare

The patient should return to her usual schedule and amount of eating and medication as soon as possible. There is a chance that she was on that schedule but another factor (infection, stress) changed the way her

body reacted to the medication and food. Removal from those situations or careful monitoring of her status in those situations in the future may help prevent a repeat occurrence.

8.3 Asthma

Asthma is a spasm of the air passages causing difficulty breathing. The air passages usually open easily during inhalation but tighten during exhalation, producing a characteristic wheezing sound as the patient struggles to exhale.

Asthma attacks can be triggered by many things:

- An allergic reaction to an inhaled or ingested substance
- Exercise
- Emotional distress
- Respiratory infections
- Cold weather

S/Sx

- Shortness of breath; coughing
- Wheezing sound on exhalation
- Chest tightness
- Increased HR and RR
- Anxiety
- Tripod position

RED FLAGS

- An asthma attack that continues for longer than 30 minutes, with or without medication
- A first-time asthma attack causing serious breathing difficulty
- Cyanosis (bluing from lack of oxygen)
- Loss of responsiveness from an asthma attack

If absolutely no reason can be found for the emergency, a patient may need to see her doctor for tests and to possibly adjust the medication taken.

Tx for asthma attacks:

- Keep the patient calm
- Remove the patient from the trigger (move away from the pollen source, move out of the cold air, move away from the police exacerbating the emotional response)
- Encourage the patient to stay in a position of comfort to ease breathing
- Pursed lip exhalations – have the patient make a tube with her lips and push the air out. This resistance to moving air may help open the air passages.
- If the patient has an inhaler, she may use it. It is beyond the scope of this training to teach you how to assist a patient in using her inhaler; if she cannot use it herself, activate EMS and utilize the highest trained medics available.
- DO NOT give the patient anyone else's inhaler. Inhalers are like pills — they have different medications in them at different doses.

Aftercare

Most people familiar with their history of asthma will be fine after an attack has ended. They may want to go somewhere and rest, but they may decide they are fine to return to the previous activity. Listen to your patient.

8.4 Fainting (Syncope)

While loss of consciousness is usually a RED FLAG, fainting is the exception. Fainting is when a patient loses consciousness for a very short time.

If possible, help the person who has fainted to the ground to minimize injury.

Stimulate the person vigorously (yelling, briskly tap- ping). Call 911 if the person does not respond within a few seconds.

Go through the initial assessment, starting with the ABC(DE)s.

After the person recovers, encourage her to lie down until medical help arrives. Even if you believe

the cause of the fainting is harmless, have the person lie down for 15-20 minutes before attempting to get up again.

Ask about any persistent symptoms, such as headache, back pain, chest pain, shortness of breath, abdominal pain, weakness, or loss of function, because these may indicate a life-threatening cause of the fainting. Also go through the SAMPLE history

Causes for fainting can include circulatory, neurological, psychological respiratory, medication/chemical or blood sugar problems as well as dehydration.

8.5 Abdominal Illness

The abdomen is one of the most “busy” parts of the body—and contains most of our organs, tightly wedged together. Many S/Sx associated with other illnesses and conditions may manifest in this region (eg. anxiety, nausea from head trauma... a very long list). Although most symptoms we encounter in this area are relatively non-threatening, we must remain

vigilant for RED FLAGS that may signal very serious situations. Our assessments and treatments address symptoms and not causes.

We are not qualified to treat or diagnose abdominal “stuff.” We do not have X-ray vision.

Common S/Sx

- Pain
- Nausea, Vomiting
- Diarrhea
- Bloating, Gassiness, Constipation

Tx:

- Hydrate
- Consider and help to problem solve possible food related causes
- See after/long-term care section
- Consult with herbalists and complimentary healthcare provider

Trauma

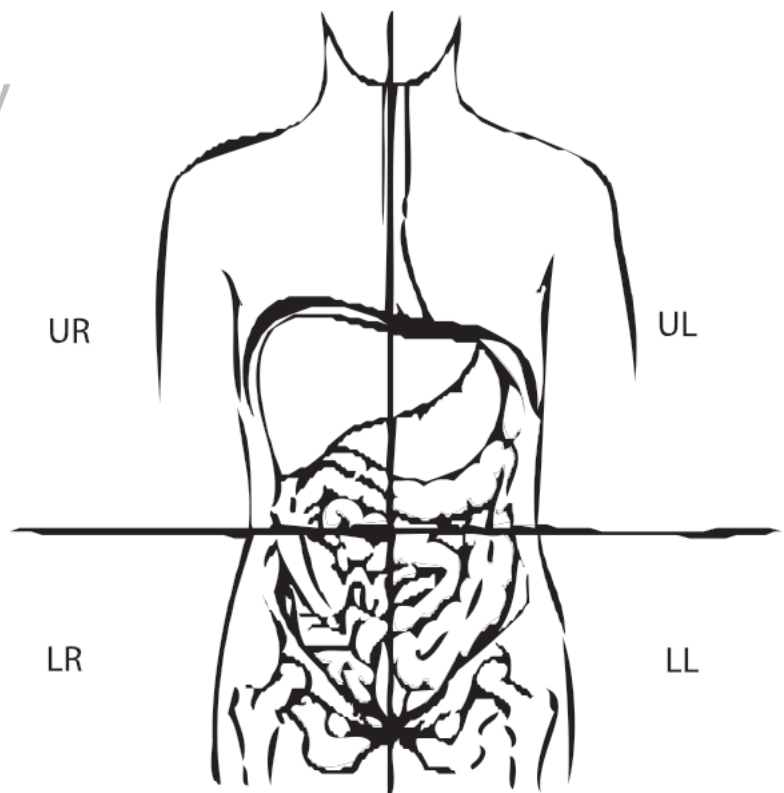
Any abdominal trauma, even seemingly minor trauma, should be noted during SAMPLE and OPQRST when taking a history and monitored for at least 24 hours. Any display of the above RED FLAGS should seek rapid medical evaluation.

RED FLAGS - “Bad Belly 8”

- S/Sx of Shock
- Blood in vomit, feces, or urine
- Persistent pain (longer than 12-24 hrs, especially constant)
- Localized pain--especially with guarding, tenderness, distension (ballooning), or rigidity
- Pain accompanies movement (jarring or footsteps)
- Persistent loss of appetite, vomiting, or diarrhea (> 24-72 hrs)
- Fever above 102°F (39°C)
- Any new or worsening abdominal complaint in the setting of known or suspected pregnancy.

Abdominal Quadrants

here be magic and mystery



Specific Illnesses:

Along with the general RED FLAGS and conditions listed above, there exist a variety of illnesses associated with symptoms felt in the abdomen. Among the more common and serious are the following:

Appendicitis

Appendicitis is a potentially life-threatening inflammation of the appendix-- generally located in the lower right quadrant (though sometimes in the left)—which if not caught early may rupture. Anyone showing rebound pain (following palpation) in the lower quadrants and/or other S/Sx of appendicitis should be transported for evaluation by a medical professional.

S/Sx of appendicitis:

- Discomfort in mid-abdomen, worsening over several hours; localizes to Lower Quadrants
- Rebound tenderness
- Pain with jarring, footsteps (hops?)
- Fever less than 102°F (39°C)
- Loss of appetite, nausea and vomiting
- If appendix ruptures, an abscess forms, which may lead to septic shock.

Tx for appendicitis

- Transport in position of comfort to hospital
- If displays S/Sx of shock activate EMS and treat for shock

Ectopic Pregnancy

Ectopic Pregnancy is a pregnancy that develops outside of the uterus, usually in a fallopian tube. Ectopic pregnancies can rupture and cause life-threatening blood loss, usually within the first 8 weeks of pregnancy. When evaluating for ectopic pregnancy we must first evaluate for pregnancy. Oftentimes this is a personal topic and must be discussed with respect for the patient's privacy.

S/Sx of pregnancy

- History of pregnancy-causing activities
- Late or missed menstrual period
- Breast tenderness and/or nipple darkening
- Frequent urination
- Nausea and/or vomiting

S/Sx of ectopic pregnancy

- Abdominal pain
- Vaginal spotting or bleeding
- Fainting
- S/Sx of shock

Tx for ectopic pregnancy

- Monitor and treat for shock
- Activate EMS or transport to hospital in position of comfort

You can't always tell whether or not someone is capable of becoming pregnant, so ask every patient regardless of their perceived gender.

9.0 Police Weapons

9.1 Chemical Weapons

Chemical weapons include pepper spray and tear gas. They may be discharged from canisters/ grenades shot or as gas dispersed widely. These canisters are very hot. DO NOT touch them with bare skin. Pepperball guns are becoming more popular among police, the paintball-like pellets are full of a powdered form of pepperspray and also cause blunt force trauma. Most often these weapons are sprayed from a can or large container like a fire extinguisher. We aren't going to differentiate between tear gas and pepperspray for the purposes of this training.

Treat symptoms, don't guess chemicals. They reformulate frequently.

Prevention

The only sure prevention is to stay home. Police are unpredictable. The Street Medic Community has clinically tested many things and has not found anything topical that can prevent the effects. See the Section 2.1 for clothing and protective gear recommendations.

Effects

Chemicals are designed to irritate the eyes and mucous membranes. Symptoms may vary from patient to patient, most patients will experience some of the following:

- eye pain
- difficulty seeing or breathing
- coughing
- intense pain on skin — it can cause a first degree burn, like sunburn
- panic (can't breathe or see)
- intense and unfocused rage

Your patient may be flailing, screaming, spitting and spluttering (remember BSIs—their body fluids will cause you pain!) Occasionally you may see convulsions, shivering, and other strange things. As always, if you don't know what's going on, say that you don't know, and get help.

Higher risk factors

- Asthma – this is the most serious common condition that escalates the effects of chemical weapons. An asthmatic having difficulty breathing is at **HIGHER RISK** than the person screaming about their eyes being on fire. Remove her to fresh, clean air and have her use her inhaler. Prior to actions, spread word that anyone with an inhaler should be sure to have it on them at the action, and consider wearing a bracelet or a note saying they are asthmatic and where they keep their inhaler. If you know someone with asthma in your protest group make sure you know beforehand where they carry their inhaler in case you have to help them get it.
- Contact lenses – the other BIG risk factor. Ask if people are wearing them and remove them immediately. Throw them out; they cannot be cleaned. Encourage people to wear glasses instead when they go to protests.
- Conditions (and recovery) affecting immune system, like HIV or medication; skin, like psoriasis or eczema; eyes, like corneal damage or infection; or respiratory tract, like bronchitis or emphysema.
- Children (especially those under the age of 6): tiny airways.
- Elderly people
- Pregnancy, nursing, or trying to get pregnant.
- Long-term steroid use (e.g. prednisone) for Crohn's disease, rheumatoid arthritis, or other reasons

Tx for chemical exposure

When approaching patients that have been exposed to chemical weapons, take a moment to call out "Who here has been sprayed?" Patients who are clearly making eye contact, who respond, "ooh, ooh me!" may not be your first priority. Remember it is often the patients who are unable to seek care that need it most.

Once you've approached a patient:

1. Introduce yourself and get consent. Remember the patient may be blinded and enraged.

2. Immediately ask if the patient has asthma or is wearing contacts.
3. Encourage calm and steady deep breathing. This will lessen panic.
4. Move patient to an uncontaminated area if there's gas in the air. Ask for consent, then put hands on patient and guide them.
5. Encourage coughing and spitting. Patient doesn't want to swallow the chemicals.
6. Flush eyes with water or Liquid Antacid with Water (LAW): we recommend 50% Maalox brand liquid antacid and 50% water. Put it in a squirt top water bottle. In the US we recommend Maalox because we know what the ingredients are. They may vary in other countries. Active ingredients to look for are magnesium hydroxide and sodium hydroxide. The anti-gas ingredient simethicone is not known to be dangerous or helpful. Check for alcohol. Alcohol, which some antacids contain, is bad for the eyes. Sorbitol, which is sugar alcohol does not seem to cause harm. We recommend Maalox brand unflavored for best results (mint works) — though some generics work also.

To flush eyes:

1. Get patient lower than you – kneeling, sitting, or hunched over
2. Tilt head to the side you are going to flush
3. Hold eyes open for patient if you need to
4. Stream water or LAW from the inside corner of the eye to the outside- be careful to not let it (and the chemicals it is moving) run across the face/ into the other eye
5. Tilt head the other way and repeat flushing the other eye
6. Tell patient repeatedly to blink. Try not to drip diluted chemical weapons onto patient. Remind patient not to touch eyes. You can also squirt LAW into patient's mouth, have them swirl it around, and then spit it out. Repeat. After several rounds, if patient's mouth feels better, they can swallow some LAW to help soothe the GI tract. This also seems to help people breathe more easily.

Decontamination

Avoid entering the house with contaminated clothing. Be aware of vulnerable people at home who you might easily expose. Take clothes off outside and put them into a plastic bag. Seal it, and don't open until doing laundry. Avoid touching anything. Take a tepid shower (doesn't need to be ice cold, as some folks may have heard elsewhere). Heat will irritate the burn. Wash clothes immediately with detergents (NOT eco-friendly stuff, which may not cut through the oil), several times if need be.

RED FLAGS

- Patient in "tripod" position- this indicates difficulty breathing. Remove them to clean air. Spread calm.
- Patient leaves the chemical weapons area and doesn't quickly breathe more easily
- Patient doesn't respond to treatment
- Unusual symptoms that don't quickly improve

9.2 Tasers, Impact Munitions, Horses

What is a Taser?

Upon contact, the Taser typically delivers a 5-second burst of 50,000 Volts electricity that overrides your central nervous system with the command to curl up into a ball clenching all muscles (officers can vary the duration of the burst as well as the number of pulses per second). Unlike old Stun Guns, this system has been proven effective even against people who are "goal-oriented" — meaning that even if you are mentally and physically prepared to resist Tasers, you will still be overcome by the electro-muscular disruption. As long as the targeted person remains connected to one of the Taser barbs, the police officer is capable of delivering further shocks.

First aid considerations

The purpose of the Taser is to aid in controlling and apprehending somebody — that is, incapacitating a person so that a police officer may arrest them. Considering this, it is unlikely that medics in a demonstration setting will treat recent Taser injuries. The following treatments can also apply as longer-term aftercare if they have not already been completed:

- Calm, comfort, reassure, empower the person; rehumanize the situation.
- Restore the electrolyte level of the person's body. This can be done with Emergen-C, or water with a banana.
- Assess and treat injuries resulting from falls
- Treat barbs as impaled objects — stabilize them and bring to further care (with consent)
- Treat burns left by the barbs.
- In the event of localized muscle spasms, ice the affected area.
- Monitor/treat for shock, advise rest.

RED FLAGS

- Injuries to the head, neck, or spine
- Prolonged vomiting and/or blood in vomit
- Blood in urine (especially if hit in back)

- This weapon takes control of a person's body away from them while simultaneously delivering a lot of pain. Remember the importance of consent when somebody has been attacked with such a frightening, dehumanizing weapon.

Wound aftercare

Be aware that pain and swelling may increase, and the area of redness and bruising may expand, for up to 2-3 days.

- Apply ice as needed as long as swelling or localized muscle spasms persist.
- Keep burn area clean and wrapped in sterile non-adherent dressing. Change dressing daily.
- Before daily dressing change, use lukewarm plain water compresses to help soak off crusting areas.
- A tetanus booster shot is recommended for anyone who has not had one in 8-10 years.
- Follow-up with an experienced healthcare worker.

Supportive care/aftercare

- Replace electrolytes by sipping nutritious fluids like water with a "sports drink" (e.g. Recharge, Gatorade) or "Emergen-C" powder with a pinch of salt and sugar added.
- Get some rest and drink lots of water.
- In addition to chemical weapons and batons the police have a number of weapons they refer to as "Impact Munitions."
- BB bags (4 X 4 in. mesh bags filled with metal BBs fired out of special guns),
- Rubber bullets (small, solid rubber)
- Dowels (usually rubber, sometimes wood)
- Pepper bullets ("paintballs" filled with pepperspray)

“Blunt Force Trauma”

They also have horses, bikes, and a variety of motorized vehicles, which they use to cause injuries that do not break the skin but can cause bruising, broken bones, and internal bleeding.

The police are trained to aim at the torso and arms with all of their impact munitions. Bikes, horses and vehicles tend to injure the legs and feet. Sometimes the head and lower abdomen are targeted or hit accidentally; this is a more serious situation.

Hardness in the abdomen area along with signs of shock and compromised vitals are signs of internal bleeding, this should be considered a life-threatening emergency.

The thighs are also an area of the body where injuries can lead to internal bleeding or shock.

The MOI is usually very severe trauma as this area is difficult to injure, however, a broken femur will often

result in shock. If the lower legs or arms are the injured body part, and this is the most common, it's important to remember that it is often very hard to tell a fracture from other types of injuries.

Horses sometimes step on feet and less often people are hit with police vehicles. These MOI's are an indicator of possible broken bones!

With the exception of very severe breaks it is very difficult or impossible to tell if a limb is broken on the street. Sometimes it will take hours or days to even suspect this is the case. We DO NOT HAVE X-RAY VISION — encourage patients to monitor their injuries and go to the hospital or seek further medical care if their symptoms worsen or fail to improve within 24-28 hours.

Indymedia, infoshop.net, zinelibrary.net, tangledwilderness.org), but until we see these weapons in the streets and treat them, our interest in these technologies should remain critical and directed to spreading calm rather than fear.

Otherwise we do the police's work for them.

9.3 Experimental Weapons

Police are secretive; we don't always know what they are planning in terms of new weapons or tactics. Although there is significant, fairly believable evidence for the existence of new sonic, microwave, chemical and other sorts of weapons, it is important to remember that not all of these weapons will be practical or desirable on the streets or battlefield. Some have already been reported retired as quickly as they were developed due to expense, cumbersomeness, legality (yes, sometimes they follow their own laws), and other rationale.

It is in the interest of politicians, military/police officials, and corporate media to keep us afraid and confused by touting new shiny tools they have for hurting us—but there have been few reports of actual use in the U.S. Should they be employed, no doubt they will appear exactly as they are: frightening machines for hurting people.

However, our role as street medics will be essentially the same: we treat symptoms—not causes. Though some of these weapons (once again, should they ever be used) may function in new and unfamiliar ways, we can treat the symptoms we see and learn from each other just as we do now with police weapons and conditions currently in use. It is useful to follow the development of new weapons (industry websites are useful for this, as well as online zine hubs—like i

Rumor Control

People at actions tend to look to medics as well-informed folks and we can use this trust given to help keep people safer. This includes controlling rumors that come our way. Medics get lots of information from different sources, often conflicting, and often inaccurate. Sharing the information you have with your affinity group or buddy can sometimes be a tricky thing. Be specific about where your info is coming from and careful as to how and to whom you relate it: "I heard a rumor that the cops are coming to the intersection from all four directions" instead of "OH MY GOD THEY'RE COMING! DOOM DOOM!" Use your best judgment in general, and err on the side of caution when in doubt, keep in mind that everything we hear is a rumor unless we see it personally, and even if we have it might not be helpful to relay the information.

When it is important to discuss information with others a helpful tool to use is to state what you see, what you've heard or know and what you feel. For example:

"I see police all around us, I've heard that more police are coming, but I feel like the police aren't going to arrest people right now because they seem to be having a cop dance party!"

10.0 Special Situations/Mobilizations

10.1 Arrest Situations

Sometimes things go very, very wrong. We may feel scared and helpless when being arrested, but the reality is that street medics can continue to do a lot of good before, during and after arrest.

Taking a “Know Your Rights” training is very helpful and highly recommended.

In a mass arrest situation, there is usually enough time to know what is coming. The crowd will probably be trapped in an area surrounded by cops. A dispersal order may or may not have been given, and leaving the area may or may not have been an actual option. The cops will likely use a loudspeaker of some kind to inform the crowd that they are under arrest.

Spread calm. Remember that people look to medics for information.

While waiting for your turn in a mass arrest, think about what you can do for those around you.

- Remove chemical weapons from people’s skin. Advise people to change into clean clothes if they have them, or remove outer layers if they are contaminated.

- Provide food and water to folks.
- Realize that there may not be a chance to use a bathroom for several hours. Make sure people around you know that, too.
- Give out the jail support phone number.
- Hugs, back rubs, smiles and sing-alongs can all help reduce tension.
- We never have to stop medicking! We can treat handcuff injuries, watch for stress related problems, and support general well-being, even after our own arrest.
- Self care! Get the support you need from those around you.

If you are the only person arrested out of a crowd, stay strong. The cops use fear as a weapon, and being alone and under the power of the cops is a very fear-inducing situation. Know that activists care, a LOT, when their medics are taken and that a little preparation in advance can greatly reduce the level of fear and stress in this situation.

For more information on arrest situations and planning, see the appendix for an article titled “What To Do When Your Affinity Group Goes to Jail (In a Handbasket).”

10.2 Medicking and Jail

Medics, like all protesters, are occasionally at risk for arrest due to mass arrest situations or because of direct action/civil disobedience. Medics have been both targeted for their support role and have been released from sticky situations because they were medics; most often medics are not treated differently than other protesters when arrested.

When medics end up in jail we sometimes have the option to continue our role as a medic by checking in with those around us, remaining calm and spreading calm, and providing rumor control. Many medics who have spent time in jail report providing

medical support to those injured prior to arrest by providing medical advocacy, reminding people to stay hydrated and calm when possible, and helping those who have been injured strategize about their options.

Jail support medicking

Jail Support Medicking is not significantly different than other forms of street medicking but medics working with those recently released from jail should be especially mindful of the mental health of their patients as they go through the medical history and be prepared to provide the patient with the resources they need to address legal, temporary housing and transportation concerns. If other infrastructure cannot fill these roles it's important that medics provide food and water to those leaving jail.

Many people leaving jail will be in need of tobacco, caffeinated products and/or other substances due to pre-existing addictions. The decision to have

tobacco, coffee and/or chocolate at jail support should be respected but it's not up to any of us to make that happen if we feel it violates the Do No Harm principle. Withdrawal from certain drugs, prescription and non-prescription, can become a medical emergency and should be closely monitored. Patients in need of medical attention leaving jail should have a thorough medical history taken as soon as possible.

Decontamination areas should be set up at or near jail support and those in need of clean clothing should have access to clothing that fits them and appropriate for the weather.

10.3 Plugging in as a Medic in a Large Mobilization

If you are going to work as a medic at a large mobilization such as those that occur at political conventions, find out what the resources will be while you're in the city. Working within the network of those providing the resources provides opportunity to learn about serving as a street medic within the community-developed infrastructure.

That infrastructure can include a convergence center where people will attend trainings, get information, network, and rest, a kitchen that delivers food to events and other spaces, legal support, independent media, and a clinic or wellness space. It can be helpful knowing where all of these places are.

Affiliating with the Clinic or Wellness Space

Clinics and wellness spaces are often able to provide extra first aid supplies, trainings, food for medics and patients, and wellness needs such as a place to rest or people to talk to. They can also tell you how communications between medics and

things like decontamination will be handled. When you arrive in town, drop by the clinic or wellness space to introduce yourself and find out how to plug in. Sometimes there are understandings about how the street medic will contribute to the clinic and interact with those working there. Some will expect you to contribute to the work at the clinic, such as keeping it clean, in exchange for any supplies you take. Interacting with street medics and other healthcare providers at a large mobilization allows us to broaden national/regional interaction and infrastructure for providing first aid to the community.

Transference of Care

The same principle of not abandoning your patient applies to transferring care of your patient to a person in the clinic or wellness space. The person should have the same or higher level of training that you have.

10.4 Affinity Groups/Actions

There may come times when, instead of running as a medic pair in a mobilization or march, one or more folks may take on the role of medic in an affinity group. In such situations, medic-patient dynamics and other aspects of a medic's role may change.

Typically, members of an affinity group will know each other before an action — in which case, preparations could include compiling medical profiles (perhaps carried with you, perhaps not) with necessary medications, information on allergies, other conditions, and other pertinent details. Your role as a medic may also include encouraging all members of your group to take proper preventative measures relative to the groups plans and potential for run-ins with various environmental hazards (police included).

Sometimes in these situations a group may be composed entirely of buddies (recommended) but a medic may buddy with another non-medic support-role, comfortable with assisting in simple tasks. In all these cases, one of the greatest assets to a medic member of an affinity group is the opportunity to plan ahead and discuss.

During an action itself (for example a lock-down) a medic's role may begin to look a lot like other support roles — you may perhaps even be tied to a single

individual or buddy pair. This can alter the prioritizing process, should your medicking services be needed elsewhere (another pre-action discussion point). Consent should always be asked, even if it seems like a mere formality among trusted friends.

It also may be harder in an affinity group scenario to separate oneself from arrestable positions. Even if one's role is purely medical, they may appear more closely tied to the action at hand and therefore be at greater risk for arrest than other scenarios. Once again, the exact nature of your role and plans should ideally be decided ahead of time to maintain trust and safety of all group members. Talk with experienced members and do your own research about safety and security protocols. Many infrastructure roles that turn up in large mobilizations (jail support, press liaison, police liaison, for example) may also be useful in smaller affinity group scenarios. Be informed. Be safe.

Medic Affinity Groups sometimes form to combine two or more sets of medic buddies. This connection may consist of shared equipment, skills, familiarity, protocols, and/or plans to stick together like glue. This may represent the entire medic contingent at an event or action — or represent a subgrouping in a larger mobilization.

10.5 Other Environments (rural, forest, water)

Although most street medics are accustomed to working in urban areas; actions and mobilizations in non-urban and other specialized environments may demand entirely new skill-sets. In wilderness responder nomenclature, non-urban situations are most characterized by their distance from emergency medical services (more than an hour for ambulance to arrive). This presents a host of different concerns that may call for greater flexibility and resourcefulness.

Many (if not most) of us are not familiar enough with our land-based knowledge of food, water, shelter, and medicinal resources to care for ourselves and friends

outside of urban centers. Knowing how and when to call for emergency services (or get in a car and drive, because it could be faster) is key—as well as how to care for your patient in the meantime.

Wilderness First Aid, First Responder, and Wilderness EMT courses are all resources for non urban settings and can be pursued through several companies. Many of these will be costly in time and money but if you can afford them (or fundraise for them!) they are worth it. **THIS IS NOT A COURSE IN WILDERNESS MEDICINE.**

Appendix: Further Resources

A.i Herbal First Aid and Aftercare

Introduction

It is easiest to learn about a handful of plants that have a wide variety of uses. There are just a few plants included in this training - but they are the ones you need to know as medics. It may also be important to get to know the plants where you are. If you're going to be in the woods for extended period of time, get to know what's there. If you're in an urban environment, know the weeds and garden plants. You can use herbs in several ways:

As a tea

Externally – Strain well and apply frequently as a wash out of a bottle or a spritzer; or dip a clean cloth in the tea and hold or tape it to the area for 1/2 hour, 1-3 times daily. Will keep unrefrigerated for about 24 hours. Internally – 1-2 cups a day.

As a tincture

Externally – For small injuries apply a dropper directly to affected area. For larger areas dilute a spoonful in ¼ - ½ cup water and apply as a wash or on a cloth.

Tinctures contain alcohol. They will burn open wounds. If someone has just been assaulted they may react strongly if caused more pain.

Internally – Standard extraction 1-3 droppers full 2-3 times a day.

As an oil or salve

Externally – Salves can be used on wounds that have been carefully cleaned. Don't use oils at demos since it can hold chemical weapons on your skin. Once you are home oils are helpful since they are easy to spread over a large area.

Don't take essential oils internally.

Rules

- Do no harm and stay within your scope; don't give someone a plant that you are not familiar with and haven't taken yourself.

- Consider timing and environment when using plants on the street: for example, giving someone a tincture for the liver will set the digestive system in motion.
- Know the proper usage, dosage, and contraindications for every plant you use.

Packing Your Kit

- Pack herbs with multiple uses and are good for common and serious issues
- Consider portability – Carry tinctures in the street or on hikes – they are less bulky than loose herbs and you will probably have less access to hot water for teas
- Pack herbs for expected MOI
- How many people do you expect to help?
- How long will the situation last?
- Other resources (What else do you have available besides your kit?)
- Nearby plants
- Cooking spices are mostly herbal medicines
- Patient needs
- Alcohol sensitivity
- Vegan/beeswax in salves
- Contraindications/warnings for plants in this training:
- Arnica is for external use only
- St. John's Wort may cause photosensitivity in some individuals
- Lavender essential oil can be used directly on the skin but should not be taken internally.

Spreading Calm

- St. John's Wort (*Hypericum perforatum*) – emotional strength, soothes nerves
- Lavender essential oil (*Lavandula angustifolia*) – calming, especially for panic attacks. Keep a bottle handy to smell throughout the day.

Weather Related Illness

Herbal First Aid: If the weather is hot, drinking water and replacing electrolytes will be most

important. If the weather is cold, the following plants can help warm the body.

- Lemon Balm (*Melissa officinalis*) – soothes nerves, fear
- Thyme (*Thymus vulgaris*) – has warming properties
- Yarrow (*Achillea millefolium*) is a vasodilator and can increase circulation to the extremities
- Ginger is warming for the GI – carry tincture or candied ginger

Abrasions and Lacerations

Herbal First Aid: In your kit carry lavender essential oil and/or a salve made with the herbs listed below. After cleaning the wound, put 2-5 drops of lavender essential oil on the bandage and/or use a tongue depressor and piece of gauze to place salve on the wound.

Aftercare: Regularly clean the wound and apply new dressings. The herbs below can also be used externally as tinctures or oils. Salves are best for kits because they won't leak or spill. Internally, they can be taken as tinctures or teas.

- Lavender essential oil – for disinfecting and promoting healing.
- Thyme – has antiseptic properties
- St. John's Wort – has anti-viral properties
- Calendula flowers (*Calendula officinalis*) - promotes healing, reduces inflammation
- Yarrow flowers - helps to stop bleeding (also good for nose bleeds) and promotes healing.

Bruises, Sprains and Strains

Herbal First Aid: For external use carry a salve made with the herbs listed below. If you want to conserve

space for other supplies, one salve can be used for cuts and bruises, but be sure to leave out the Arnica. Arnica can cause bruising around the edges of wounds and skin irritation on broken skin.

Aftercare: The herbs below can also be used externally as tinctures or oils or a strong tea can be added to a warm bath. Internally, they can be taken as tinctures or teas. Encourage people to eat raspberries, blueberries, cherries, and blackberries – they are high in the phytochemical anthocyanadin, which strengthens arteries and blood vessels.

- Arnica flowers (*Arnica montana*) – reduces pain and inflammation and encourages healing
- St. John's Wort flowers (*Hypericum perforatum*) - reduces bruising and nerve damage
- Calendula flowers (*Calendula officinalis*) - promotes healing, reduces inflammation
- Yarrow flowers (*Achillea millefolium*) helps to stop bleeding and promotes healing.

Burns

Herbal First Aid: Add 2-5 drops of lavender essential oil to the dressing.

Aftercare: Make a poultice of any of the following to cool inflammation and promote healing:

- St. John's Wort flowers (*Hypericum perforatum*) - for nerve damage
- Plantain leaves (*Plantago lanceolata* or *major*) - cool inflammation and promote healing
- Comfrey leaves (*Symphytum officinale*) - cool inflammation and promote healing
- Raw potato, grated carrot, or tofu - cool inflammation

A.ii Herbal Care of Handcuff Injuries

Handcuff injuries are one of the most common injuries among arrestees. Plastic flexi-cuffs are generally used for protesters. They tend to be very tight, bringing the arms closer together. Quite often arrestees are unable to move their hands. Both of these things decrease circulation with the potential result of nerve or tissue damage.

Prevention

Prevention of handcuff injuries is the best way to go. If you aren't putting yourself in danger, try the following:

Spread calm

Even if you or someone else has or is at risk for an acute injury from handcuffs, stay calm. Arguing and getting angry will make it less likely you'll get the handcuffs removed.

If you can talk to those arrested, ask them how their hands are feeling. They might be experiencing pain around the thumb, numbness, tingling.

Advocate

Advocate for removal/or loosening of the handcuffs. Explain your concern calmly and clearly to the police. For example: “I’m a medic/WFR/EMT/ That person is experiencing numbness/pain/tingling in their hands. They could suffer permanent nerve damage if the handcuffs are not loosened immediately.”

Ask each cop you talk to twice, and then ask someone else. If someone says that they are doing something about it, try to write it down, including the cops name, rank, and badge number.

Folks who’ve had handcuffs on too tight or for an extended period of time are more likely to have serious injuries from handcuffs.

Remind other people in the area to keep an eye out for folks experiencing pain from handcuffs, tell them to look for people whose hands are discolored.

If anyone complains of tingling or numbness, advocate for them!

S/Sx

Changes in sensation or pain will usually occur along the edge of the hand between the base of the thumb and the wrist.

It can also extend to the back of the hand below the first two fingers (forefinger and middle finger), and/or the back of the thumb and the backs of those fingers. In most cases, damage from handcuffs is not serious and will heal. If you have a patient who has handcuff injuries, test for any muscle weakness in the hand, thumb or fingers.

Tx for handcuff injuries

- Examine the hands, wrists, and forearms: When someone is coming out of jail, ask if you can check their hands for circulation, sensation, and movement. Before you check for sensation, ask them to tell you what they feel because you’re more likely to get accurate information. Pain will subside some when the handcuffs are removed, but there is often altered or decreased sensation.
- Once someone has had their handcuffs removed and you’ve checked CSM, try to encourage blood flow by having them stretch, roll their shoulders, do arm circles, clench and unclench hands,

- Remind them that if an area wasn’t getting enough blood flow, it can be painful to go through the process, but that this is a really good sign.
- Compare hands
 - Ask the person to squeeze your fingers, ask if they experience weakness.
 - You can also hold a piece of paper and have the person try to take it from you.
 - Lightly touch each of the fingers and the base of the thumb, the wrist, and the forearm
 - Squeeze the fingers and thumb
- Look for total numbness in any part of the hand, and wait a bit. Usually sensation should start returning within a few minutes. If it doesn’t, or if it gets worse, this may indicate that a nerve has been cut and you should get that person further care.
- Look for numbness on upper 2/3 of forearm could indicate damage to neck, spine, or arm.
- Inquire about MOI and possible injury prior to handcuffing—you are looking for anything that may have caused damage to the spine (isn’t very likely but important to check).
- Look for bony, point tenderness - refer to musculoskeletal section! Recommend X-ray if this is the case.

Herbal First Aid and Aftercare

Clean any wounds then apply salve with the herbs below to the wrist or areas experiencing pain, swelling, and/or loss of CSM. Massage the oil on their wrist (remember gloves, or you can use a Q-tip, cotton ball or 4x4) or put some in their hands to use on themselves. Don’t use oil at an action because oils trap chemical weapons on the skin.

- St. John’s Wort: reduces bruising and nerve damage
- Arnica: reduces pain and inflammation and encourages healing – DON’T use externally if the skin is broken.
- Calendula flowers: promotes healing, reduces inflammation

Note: If someone has major nerve damage, the sooner the treatment is started the better possibility for recovery. There are many different possible treatments for these folks including physical therapy, herbs, acupuncture and bodywork. Help these folks find resources!

A.iii Herbal Chemical Weapons Aftercare

Exposure to “incapacitating agents” such as tear gas and/or pepper spray may damage the protective lining of the lungs, which can make us more susceptible to lung infections and diseases. Activists who have been exposed often experience lingering respiratory disorders. Additionally, the toxins from the chemical weapons can stick around in our bodies, taxing our liver and our general immune system. There are many steps you can take to help decrease your risks from exposure to these toxins. Some of these steps need to be taken as soon as possible following exposure. Others should be done regularly over the weeks before and after exposure.

Herbal First Aid

After flushing eyes, encourage people to decontaminate themselves at home or at the activist clinic if one is set up at a major convergence. Remind them to not bring contaminated clothing indoors unless wrapped up in a plastic bag and to wash hair and all contaminated clothing in a strong detergent.

Aftercare

Aftercare for chemical exposure breaks down into three parts: treatment of burning skin, lung support, and liver support (and general detox).

Skin

Flush skin with cool water for at least 10 minutes. Calendula, Plantain, and/or Chamomile - Use wet paper towels or gauze to apply a cooled tea, rewet as needed.

DO NOT USE ALOE VERA ON PEPPERSPRAY BURNS. It may seal chemicals in much the same way that it can seal in a staph infection in a wound.

Lung

- Mullein leaf (*Verbascum thapsus*) - excellent lung support. This should especially be used if you are asthmatic or have a cough.

- Malva root (*Malva neglecta*) – common name is Cheeseweed – related to Marshmallow and Hollyhock – these are mucilaginous (slimy) herbs that soothe and coat mucous membranes. These are especially important for people who inhaled chemicals like pepperspray or tear gas.

Liver and General Detox

- Drink at least 2 liters of water a day — more if you can.
- Liver support: Use bitter, liver tonic herbs such as Milk Thistle seeds (*Silybum marianum*), Burdock root (*Arctium lappa*), and Dandelion root (*Taraxacum officinale*) for about two weeks following exposure. Your liver must work overtime to filter out the toxins. Avoiding alcohol, cigarettes, caffeine, fried or high fat foods will make its job easier. Getting regular sleep is also important — your liver continues to work while you sleep.
- Eat whole grains and brightly colored vegetables and fruits.
- A hot shower, followed by a thorough scrubbing with Epsom salts which are then left on the skin for 10-15 minutes before a thorough follow-up wash can help draw toxins from the body. Be sure to accompany this with much water consumption.
- Nettles are the perfect all around support plants. Their high mineral content and mild cleansing action supports many body functions. The phytonutrients boost the immune system, the minerals soothe nerves and muscles and strengthen bones and connective tissue.

B. Emotional Aftercare (Avoiding Burnout)

Being at a protest can expose us to all kinds of things that have the potential to cause trauma or emotional distress. Signs of this include:

- Not feeling in the body, a sensation of floating, numbness
- Staring off into space (the “thousand yard” stare)
- Hyper vigilance or jumpiness (flight-fight syndrome)
- Feelings of hopelessness, anxiety, or depression
- Obsessive thoughts, replaying the event over and over, like a slideshow when you close your eyes
- Fixation on stimulation or disassociative activities

Remember that these responses are normal responses to a traumatizing situation.

Things to do

- DON'T expose yourself to imagery of the event until you've had some time to recover from it. This can cause the obsessive thoughts, flashbacks, anxiety, or “slideshow” to worsen.
- Take long walks in the woods or through parks and gardens.
- Talking about the event can be very helpful for some people. A same day debrief is ideal – remember that it is a shared experience and talking about it can help you begin reconnecting. It can be especially important to talk with people who were at the event, because sometimes it doesn't help to try and explain what happened and what it means to you to someone who wasn't there. This is not to say that you shouldn't talk to people who weren't there. Just something to keep in mind as you recover.
- Connecting with others. Spending time with good friends, families, and lovers can be helpful.
- Finding safe space. This means something different for each person.
- Make space for silence. Allow time for the mind to settle.
- Practice grounding techniques or other activities that make you feel “in your body.” Stressful events can cause us to disassociate or “leave our bodies.” This can lead to depression, anxiety, and a sense of loneliness. Coming back to ourselves will help us develop resilience. Being

able to bounce back from the stress of a protest means that you can recover more quickly – this is part of sustaining the movement.

- Recognize your personal needs. Some people really need to have a drink afterwards – if that's truly what will help, do it. But also recognize that some choices actually prevent recovery and worsen any dissociative effects someone might be feeling.
- Be patient: recovering takes time. Don't be hard on yourself if you need to take some time off as a medic or from another aspect of your life. Maintaining good mental and emotional health is more important.

Herbal First Aid and Aftercare

- St. John's Wort – soothes the nervous system, uplifts and strengthens emotions
- Lavender essential oil – smelling the oil releases tension in the head, relaxing, soothing
- Calendula – helpful for people who are having a hard time talking about their experience
- Yarrow – helpful for people who feel vulnerable after a demo
- Lemon Balm – lifts depression, alleviates insomnia, soothes anxiety
- Malva – helpful for people who are having difficulty acknowledging their emotions.

What are some ways you practice self-care and avoid burnout?

C. Documenting Injuries & Chem Weapons Exposure

The material in this section is adapted from “Shooting the Wounded” by the Midnight Special Law Collective in San Francisco (www.midnightspecial.net).

Why do we teach this at a street medic training?

Street medics are often targeted by police and arrested and injured. It is important for you to know how to document your own injuries. You may wish to document your injuries for lawsuits and/or media coverage. Consult with a legal worker before emailing or posting photos or videos on the internet. You can also encourage people you help to document their injuries.

Why document injuries and exposures to chemicals?

Police in many U.S. cities attack the individuals most oppressed by social inequalities, exploitation, and poverty - people of color, poor people, transgender people. When police overstep boundaries, most victims don't have the knowledge or resources to seek “justice” in the legal system. Medics, activists of color, and trans activists are often targeted and sometimes have worse injuries.

There is no guarantee that you will win your case against the police, but having photos or video of your injuries will improve the odds. Also, reports from a doctor at a free/low cost clinic (such as Outside In, Portland) can create a record of the injuries that don't show up on film: torn muscles, concussions. Documenting your injuries simply means that you get written and visual proof of them so that even after they've healed, you have proof that they existed. If you are thinking of suing the police or filing a complaint, evidence of brutality will help you build a stronger case. Here are a few tips to make documenting easier.

How to photograph injuries and the scene of the incident

- Even the marks of severe injuries can disappear quickly. Without good photos, you might lose those injuries as evidence of police brutality. Generally, the darker your skin is the less you

injuries will show up on film, and the more important it is to follow these guidelines.

- Have someone take a picture of your whole body. Then take a few photos as they get closer to the injury.
- Take photos as close as possible to the injury to show the most detail.
- Try photographs from different angles, with different light (direct sunlight, indirect lighting).
- Be careful not to use a flash when taking a close-in photo. Flashes, bright light, and spotlights right on the injury tend to reflect off the skin and make the bruise or other injury appear lighter than it is.
- If the injuries are big, put a ruler next to it in one of the photos to show how big it is (but make sure you take some photos without the ruler, to show you aren't hiding anything). If you don't have a ruler, use something with a standard size, like a dollar bill.
- Don't rely on any one photo to show your injury. You should take at least four photos of each injury.
- Take photos every day or every other day to show how they change. For example, bruises can take a few days to fully darken.

Talking to health care professionals

- Go to a doctor you can trust as soon as possible. If you can't afford to pay for one, check available resources for clinics/clinicians that provide free/low-cost treatment.
- Make sure you keep a record of the names of all of the doctors, medics, and nurses that see your injuries.
- Tell every nurse, technician, and doctor who looks at you about each of your injuries (including less severe ones) and how you got them.
- Ask them to write down your injuries in detail, especially injuries you can't take photos of, like sprains, strains, broken noses or broken ribs.
- If the doctor recommends follow up treatment or appointments, it's important to go. This will give you more credibility and let the doctors keep documenting your injuries.

- Hold onto any forms you get from anyone at the hospital/clinic.
- Make a file to keep all documents in one place and keep a back up.

Warning

It can be risky going to a hospital right after being injured by the police, especially during large protests. Emergency room workers often call the police if activist-looking people come in for help. More than one activist has ended up in jail after going to the hospital to have an injury documented.

However, there are steps you can take to keep yourself safe: go to a doctor you have a relationship with, go to a hospital or free clinic across town (or in a different town) from the protest, and be dressed up “nice.” Of course, if it’s a potentially life-threatening injury, consider taking the risk of going to the closest hospital. If you’ve already been cited and released or gone to jail and been released, you don’t risk as much by going to a hospital and telling them exactly what happened to you.

Other evidence

- Keep a diary of all of your injuries as they progress and heal.
- Keep all evidence! Including rubber bullets or tear gas canisters. If you have bloody clothes, put them in a garbage bag and hold onto them in a freezer.
- Hold onto all paperwork you get from the cops or the court (e.g. arrest report, property receipts, booking photos).
- Tracking this information can be helpful when building your case. A police misconduct report is included in the appendix.

Other legal things:

As used in this section and ORS 30.805 (Liability for emergency medical assistance by government personnel), “emergency medical assistance” means:

(a) Medical or dental care not provided in a place where emergency medical or dental care is regularly available, including but not limited to a hospital, industrial first-aid station or the office of a physician, physician assistant or dentist, given voluntarily and without the expectation of compensation to an injured person who is in need of immediate medical or dental care and under emergency circumstances that suggest that the giving of assistance is the only alternative to death or serious physical aftereffects; or

(b) Medical care provided voluntarily in good faith and without expectation of compensation by a physician licensed under ORS chapter 677, a physician assistant licensed under ORS 677.505 (Application of provisions governing physician assistants to other health professions) to 677.525 (Fees) or a nurse practitioner licensed under ORS 678.375 (Nurse practitioners) to 678.390 (Authority of nurse practitioner and clinical nurse specialist to write prescriptions or dispense drugs) and in the person’s professional capacity as a provider of health care for an athletic team at a public or private school or college athletic event or as a volunteer provider of health care at other athletic events.

(2) No person may maintain an action for damages for injury, death or loss that results from acts or omissions of a person while rendering emergency medical assistance unless it is alleged and proved by the complaining party that the person was grossly negligent in rendering the emergency medical assistance.

(3) The giving of emergency medical assistance by a person does not, of itself, establish a professional relationship between the person giving the assistance and the person receiving the assistance insofar as the relationship carries with it any duty to provide or arrange for further medical care for the injured person after the giving of emergency medical assistance. ^{[1967}

c.266 §§1,2; 1973 c.635 §1; 1979 c.576 §1; 1979 c.731 §1; 1983 c.771 §1; 1983 c.779 §1; 1985 c.428 §1; 1989 c.782 §35; 1997 c.242 §1; 1997 c.751 §11; 2013 c.688 §8; 2014 c.45 §3]

D. Kits

Medics carry gear. Sometimes we're gear-heads. Gear is cool so feel free to indulge, but remember we really don't need much to do a lot of good. Our knowledge is the best resource we have on the streets (including knowing what we don't know and when to get help). After that, most medics value water as their favorite thing to carry, their cell phone as a tool for getting help and staying informed, and their gloves for touching patients. But, if you're into carrying more than water, a phone and gloves, here is a list of what we've found useful. Be sure to carry only supplies that you know how to use for skills within your scope, and that the things you carry are in good working condition and protected from chemical weapons while in the kit.

Sample First Aid Kit

Personal/Protective

- Two pairs of goggles
- Several bandanas
- Earplugs
- Lip balm
- Snacks
- ID and/or emergency contact info if you want to be cited and out of jail in the event of arrest
- Just enough money for pay-phone, food, transportation
- Watch, paper, pen for accurate documentation of events, police brutality, injuries
- Inhaler, epipen, insulin or other prescription meds for yourself if needed, extra glasses if you wear them, several days of prescription medication

Prevention

- Gloves - twice as many as you think you might need, stored cleanly
- Sunscreen (water-based) for yourself and to give out

- WATER for yourself (camel back style water bottles are great; be careful to keep pepperspray off the hose!)
- WATER to give out - squirt bottles work well (people don't have to put their lips on it to drink from them)
- Snacks to give out (vegan, watch for common allergens!)
- Hand sanitizer
- Emergency blanket/bivy sacks

Chemical weapons

- Squirt bottle for LAW
- Squirt bottle for water
- Extra Maalox
- More gloves

Other

- Bulky dressing for stopping large bleeds (like menstrual pads)
- Flashlight
- Safety pins
- EMT shears
- Notebook and/or SOAP notes
- Thermometer
- Rescue remedy
- Herbs you know and have used before
- Emergen-C type powder

Wound care

- Band-aids
- Tea tree or double antibiotic ointment
- Gauze pads
- Tape
- Tweezers
- Flushing syringe
- Burn ointment
- Antiseptic towelettes
- Green soap sponges
- Second skin for burns
- Mole skin for blisters

E. When Your Affinity Group goes to Jail

A guide for medics on the outside with buddies on the inside; or, When Your Affinity Group Goes to Jail (In a Handbasket)

Keep yourself safe

You can do more good on the outside than going down with your buddy.

Go to your safe space

Or send someone, and find the paper where your buddy wrote down their legal name (or their intent to use J. Doe) and whatever needs they have.

Take care of those needs

Find someone to feed the cat, figure out where the car is and use the spare key which was left with the note to move it to a safer place. It takes hours before your buddy will be released - take care of urgent needs before settling in to make calls and wait.

Find the phone number for the jail

To call and check on your buddy's status. Especially in a mass arrest, it may be a few hours before your buddy hits the system. Call every hour or so to check on the status - find out if bail is set, and how much, and when it can be posted, or find out when the arraignment or bail hearing will be. This helps them remember that folks are waiting and caring.

Mass pressure can be a good thing. If a vegan isn't getting vegan food, if a trans person is in the wrong jail and wants to be moved (BE CAREFUL about outing a trans person - rumors fly, the best way to know is to talk beforehand about where the person wants to be housed and what they want to do if they're in the wrong place, and to confirm with the jail where the trans person actually is housed before outing them), have every person around you call every number you have - the main jail number, any other jail numbers you can find, the police non-emergency line, the county sheriffs office, the mayor's office, and anyone else you can think of. Be clear about what you want - demanding the release and charges dropped of all mass-arrested folks is hopeful and fun, but it may be more

important to demand that X person be kept somewhere safe, that all vegans receive vegan food, and that all folks be arraigned within [whatever the time limit of that jurisdiction is - usually 24 hours].

Utilize the jail support phone number

(If there isn't one, hopefully the community will learn the lesson and set it up next time). Call them and leave your buddy's name (if your buddy is going to use J. Doe, have a code name which they and you can use with jail support) and messages, such as, "The rest of us are out, the cat got fed and we're waiting for you" or whatever your buddy might like to know. Call back to jail support to see if your buddy has contacted them - it's likely that's the only number your buddy can call at first (because it's a legal support number, and will be local and accept collect calls and all that).

Utilize Inmate Calling Services (ICS)

To make an account where your buddy can make outgoing phone calls. This service is not part of the jail system. It works kind of like prepaid phone minutes except instead of being attached to a cell phone, those minutes are set up to be used between a specific jail and a specific phone number (your cell, your house, whatever). The number for ICS is 1-888-506-8407 and you should have a credit/debit card ready to set up the account.

The person in jail won't know when the account is set up - all they will have to do is dial the number, and if it goes through, the account is working; if it doesn't, it's not working. Anyone in the same jail can dial that number and get through.

Have a plan before the action for what number will be set up with an account. Write this number on your body along with the jail support number. At larger mass-arrest-likely actions, it may be best to leave 1 person's cell phone at the safe place with the info sheet, and already have an account set up that runs to that phone from the local jail - then, as soon as someone gets arrested, someone else can go get that phone and be ready for calls. These paid accounts can be cancelled for a refund when you're done.

Do courtroom support

If your buddy will have a hearing before being released, plan for as much support in the courtroom as possible. Hearings are open to the public, but you may have to show ID to get in, and you cannot bring any type of bag or electronic stuff in with you (this includes cell phones, but sometimes you can bring in a laptop). Bring pen and paper to write down important details. Your buddy will NOT walk out of court with you, even if the judge orders a PR (free) release - it will still take hours to be processed out.

If your buddy will be held a few days

(Such as in a mass arrest, or if held on high charges) write them letters and stick them in the mail immediately so they have a chance to get there before your buddy is released. Even if they do not get to your buddy, it really helps folks on the outside to write them. If your buddy has been released when the letters arrive, they will probably be returned to sender. Remember, no crayon or colored markers, just ballpoint pen, and no information that you don't want the police to have. Hand-drawn pictures of nature are really nice to receive.

Bail

In most places, bail must be paid in actual green cash, no checks or cards taken. Prepare for this - know where the money is and how to access it. There is usually a daily limit on ATM withdrawals, but sometimes if you call your bank and tell them you need more than that, they'll lift that limit and you can get what you need.

Waiting

Waiting outside the jail can be hard on folks, but walking out of jail into the arms of your affinity group means so much. Take care of yourself while waiting outside - be warm, eat good food (usually not a problem at jail support, usually it is provided), share love. Be aware that sometimes folks will get dropped off somewhere away from the jail - be ready with a phone your buddy knows the number of to get a call from them somewhere else in the city.

When your buddy gets out

When your buddy gets out, be aware of potential damage done to them. It's tempting to rush them and tackle them to the ground, but that may be exactly what the cops did to them. Ask before touching, hugging, grabbing and mobbing, and continue checking in about whether it's still okay. Celebrate, but remember your buddy's physical needs - food, water, medical care, sleep. Advocate for your buddy to get what they need now that they're out. Being listened to is very important when someone gets out of jail. If you can't handle hearing your buddy's stories, help them find someone who can. Sometimes there are peer counselors at activist clinics, sometimes you can find one at jail support, or maybe a medic or legal observer or just another familiar face can listen.

Let people know your buddy is out

Call the jail support number and tell them your buddy's out. Call the friends back home, the folks at the clinic, whoever else knew your buddy was in and let them know they're out.

Help your buddy get their stuff

Deal with getting your buddy's possessions back if they weren't released with them. They should have a sticker or tag or tracking number or something to identify their belongings. Call the jail and find out where the property is and when it can be picked up. It probably has to be picked up by the person. Make arrangements to get your buddy there and help them deal with whatever is missing in the meantime - house keys, wallet.

Going back out

If your buddy wants to go back out on the streets, don't try to talk them out of it based only on "you were just in jail." If there are reasons for them to not go ("you need stitches in that cut; you just said you haven't slept in 40 hours") then present them in a reasonable and loving way. If they're going out and you can't go with them, help them find another safe and reliable buddy to go. Being arrested twice at one action doesn't necessarily make it worse the second time, although it does double the chance of having a charge that sticks or goes to trial. If your buddy doesn't want to go back out, support that decision. If they want to work, maybe they can

do clinic work or jail support during the remainder of the action. Remember to help them take care of themselves during this time - to eat, rest, and utilize the support community, but also remember that working may be exactly what they need to heal and feel normal again.

It doesn't end here

Remember that it doesn't end here. There may be a trial, there may be court solidarity, there may be a civil suit. Let your buddy choose what direction to take in all of this, and support whatever decision they make.

Folks are often overwhelmed with the system - it's designed to make us feel powerless. Your buddy may need help doing even simple things like calling the public defender's office, finding a lawyer,

checking on court dates. It may help to assign one non-arrested person from the affinity group to aid each arrestee personally, or maybe one person in the group can coordinate with all the arrestees. Remember that this can take months to sort out - this is not a day long commitment.

Ask what your buddy's needs are

Ask frequently what your buddy's needs are over the coming weeks. Maybe they need help replacing things still in police custody, maybe they need continuing medical care for injuries. Likely, they need to keep being around friends and support folks who will keep listening to and sharing in their stories.

Police Misconduct Report

Note: Be as accurate and detailed as you can (and don't guess!). Give this form to your lawyer. If you don't have a lawyer, contact the National Lawyer's Guild's hotline at 415-285-1041.

Your Name:	Email:	Phone:	Today's Date:
			Address:

Date, time and exact location of the incident (include cross streets as well as street address and any landmarks):

Victim 1:

Name: Email:

Phone: Address:

Description of victim (include gender, race, age, height, weight, build, clothing, glasses, hair color/style, etc.) Be as detailed as possible:

Victim 2:

Name: Email:

Phone: Address:

Description of victim (include gender, race, age, height, weight, build, clothing, glasses, hair color/style, etc.) Be as detailed as possible:

Officer 1:

Name: Badge #:

Organization: Rank:

Vehicle type: Vehicle #:

License Plate #:

Description of officer (include gender, race, age, height, weight, clothing and insignia, hair color/style, weapons, vehicle, etc.) Be as detailed as possible:

Officer 2:

Name: Badge #:

Organization: Rank:

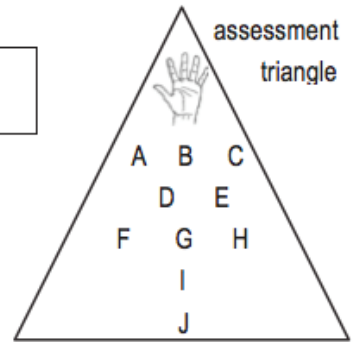
Vehicle type: Vehicle #:

License Plate #:

Description of officer (include gender, race, age, height, weight, clothing and insignia, hair color/style, weapons, vehicle, etc.) Be as detailed as possible:

SOAP Note

Basic Information		Medic Name:	
Date	Pt Name	Emergency Contact	
Time	Address/Phone	Height/Weight	
Age/DOB	Location	Pronoun(s)	



Subjective

S *signs & symptoms* _____

A *allergies* _____

M *medications* _____

P *past pertinent history* _____

L *last in/out* _____

E *events* _____

MOI / NOI / Chief Complaint:

Objective

<p><u>front</u></p>	<p><u>back</u></p>
---------------------	--------------------

O *onsets* _____

P *provokes / palliates* _____

Q *quality* _____

R *radiates / refers / region* _____

S *severity* _____

T *time* _____

Assessment

<u>vitals</u>							
<u>time</u>	LOR	HR	RR	SCTM	PERRL		

Plan

Turned Pt Over to: _____

at _____

